

“LIKE ANY OTHER WOMAN”? PREGNANCY, MOTHERHOOD, AND HIV  
AMONG SEX WORKERS IN SOUTHERN TANZANIA

by  
Sarah W. Beckham

A dissertation submitted to Johns Hopkins University in conformity with the  
requirements for the degree of Doctor of Philosophy

Baltimore, Maryland  
December, 2013

© 2013 Sarah W. Beckham  
All Rights Reserved

## **Abstract**

**Background:** As women of reproductive age, female sex workers (FSWs) have reproductive health needs, fertility intentions, and families. However, given FSWs' work environments and the societal stigma against them, there are unique dynamics to consider for their sexual and reproductive health, including the heightened risk of HIV and other sexually transmitted infections (STI). This study examined the social context and role of motherhood and fertility in relation to FSWs' HIV risk and overall health and wellbeing.

**Methods:** FSWs were recruited through purposive sampling. They were eligible if they were at least 18 years, exchanged sex within the last month, and worked in entertainment venues. In-depth interviews (IDIs) were conducted with 30 FSWs, three focus group discussions with 22 FSWs, and 13 key informant interviews with health care workers, bar owners/managers, and staff of non-governmental organizations.

**Results:** FSWs in IDIs were age 20-40, reported 77 pregnancies, and had medians of two pregnancies, live births, and children. FSWs had intended pregnancies with partners and clients; the contexts in which they sought these pregnancies sometimes put them at risk for HIV. When seeking antenatal care, FSWs reported being denied care for attending without husbands. When FSWs used contraception, they accessed care and were treated "like any other woman," but this care was not tailored to their unique needs based on HIV/STI risk, partner types, and specific fertility desires. Sex workers who were mothers were well aware of the risks they could encounter in their jobs, but with children to support, they were constrained in their choices. This led to both increases and decreases in reported HIV-related risk behaviors.

Conclusions: The context of FSWs' lives as women of reproductive age and as mothers impacts their work and HIV-related risk behaviors. Thus, looking beyond the individual-level risks to the structures and social environments in which FSWs live and work is important to understand the various factors that impact their abilities to protect themselves. In turn, recommendations to inform policy and programmatic interventions for FSWs are highlighted with particular attention to their reproductive health needs and desires as well as their roles and responsibilities as mothers.

Readers:

Deanna Kerrigan (advisor)

Peter Winch (co-advisor)

Chris Beyrer

## **Preface**

I am grateful for the following funding from various centers and endowed student support funds through the Johns Hopkins University and Bloomberg School of Public Health: Doctoral Dissertation Research Abroad Award; Center for Communication Programs Research to Prevention Doctoral Student Initiative; Georgeda Buchbinder Memorial Fund; Marjorie F. and Joseph I. Berman Family Award; and the Center for Qualitative Studies in Health and Medicine Dissertation Enhancement Award. I also received funding through the Fulbright-Hays Doctoral Dissertation Research Abroad Fellowship.

Thanks to Peter Winch, Deanna Kerrigan, and Chris Beyrer, who were thesis committee members, advisors, mentors, and also friends and cheerleaders. I would like to acknowledge Justin Beckham, Haneefa Saleem, Heena Brahmabhatt, and Gundula Fischer for their input on drafts of chapters, as well as various conference attendees who reacted to my presentations and posters at multiple stages of analysis. A big thanks to Ann Biersteker, who guided me through Swahili literature and helped me translate proverbs without losing the nuances in translation, and to Gary Thomas “Zuberi” Burgess who introduced me to Swahili and Tanzania.

The research team for the Strategic Assessment to Define a Comprehensive Response to HIV/AIDS in Iringa, Tanzania, also deserve thanks for allowing me to imbed my research within their project: Caitlin Kennedy, Deanna Kerrigan, Heena Brahmabhatt, Jessie Mbwambo, and Samuel Likindikoki.



I express my heartfelt thanks to my research assistant, recruiter, data collector, and transcriptionist, Catherine Shembilu, who contributed more to this research and development of ideas than I could have hoped for in an assistant. Thanks also to Isaak Lwechungura for transcribing.

Of course I owe so much to all the participants who willingly shared details of their work lives as well as their private lives. *Ninawashukuru sana.*

*Ninamshukuru pia Agnes aliyenisaidiaga kila siku kwa kufanyia kazi za nyumbani ili mimi niwezage kujificha ofisini (bila uchangamfu) kuandika kitabu hichi. Ndilumba hilo.*

Thanks to all my friends in Baltimore and Iringa who helped me stay sane, especially Chase and my other fellow SBIers, my band *Mitumba*, visitors, roommates, and all the kids in Teenagers' Clubs. I express appreciation and love to my parents, Rick and Shelley Wilson, who taught me that a girl could be anything she wants when she grows up.

Finally, I express my undying love and gratitude to my husband, Justin, and son, Juma, who tolerated the "Do Not Enter: Working" sign on my home office door; moved to Baltimore and then to Tanzania with me; forgave far too many (inappropriate) public health-related conversations over dinner; and showed unfailing love and support throughout this crazy PhD thing. *Nawapenda daima.*

## **Dedication**

For Vicki  
who believed in me even when it was hard  
March 31, 1954-June 23, 2010

# Table of Contents

<b>Chapter 1. Introduction</b>	<b>1</b>
1.1 Study Objectives	1
1.2 Conceptual Framework	3
1.3 Organization of the Dissertation	7
<b>Chapter 2. Relevant Literature and Study Setting</b>	<b>9</b>
2.1 Theoretical Perspectives	9
2.2 Epidemiology of HIV among Female Sex Workers in Tanzania	14
2.3 Epidemiology of Sex Work and Reproduction	16
2.4 Motherhood, Sex Work & HIV	18
2.5 Study Setting	23
2.6 Contribution to Public Health	34
2.7 Tables for Chapter 2	36
<b>Chapter 3. Methods</b>	<b>37</b>
3.1 Recruitment, Sampling, and Data Collection	37
3.2 Data Analysis	43
3.3 Ethical Considerations and Protection of Human Subjects	45
3.4 Tables for Chapter 3	48
<b>Chapter 4. “Do You Have a Husband?: Female Sex Workers’ Experiences with Intended Pregnancy and Antenatal Care Services in Southern Tanzania”</b>	<b>49</b>
4.1 Abstract	49
4.2 Introduction	50
4.3 Methods	53
4.4 Results	57
4.5 Discussion	67
4.6 Tables for Chapter 4	74
<b>Chapter 5. “A Qualitative Exploration of Female Sex Workers’ Experiences with Contraception in Southern Tanzania”</b>	<b>77</b>
5.1 Abstract	77
5.2 Introduction	78
5.3 Methods	79
5.4 Results	80

5.5	<i>Discussion</i>	85
5.6	<i>Tables &amp; Figures for Chapter 5</i>	89
<b>Chapter 6. “If You Have Children, You Have Responsibilities: Motherhood, Sex Work, and HIV in Southern Tanzania”</b>		<b>92</b>
6.1	<i>Abstract</i>	92
6.2	<i>Introduction</i>	94
6.3	<i>Methods</i>	99
6.4	<i>Results</i>	102
6.5	<i>Discussion</i>	111
6.6	<i>Tables for Chapter 6</i>	121
<b>Chapter 7. Conclusions</b>		<b>123</b>
7.1	<i>Summary of Results</i>	123
7.2	<i>Strengths and Limitations</i>	130
7.3	<i>Recommendations for Future Research</i>	133
<b>Chapter 8. Policy &amp; Programmatic Recommendations</b>		<b>138</b>
<b>Chapter 9. Appendices</b>		<b>149</b>
9.1	<i>Appendix 1: Maps</i>	149
9.2	<i>Appendix 2: Venues</i>	153
9.3	<i>Appendix 3: Data Collection Instruments</i>	158
<b>Chapter 10. Bibliography</b>		<b>190</b>
<b>Chapter 11. Curriculum Vita</b>		<b>204</b>

## Tables

<b>Table 1.</b>	<b>Reproductive Histories &amp; Indicators among Female Sex Workers</b>	<b>36</b>
<b>Table 2.</b>	<b>Research Participants by Type of Participant and Interview</b>	<b>48</b>
<b>Table 3.</b>	<b>Demographic Characteristics of Female Sex Workers (n=30)</b>	<b>74</b>
<b>Table 4.</b>	<b>Reproductive Histories of Female Sex Workers (n=30)</b>	<b>75</b>
<b>Table 5.</b>	<b>Reported Paternity of Pregnancies (n=77)</b>	<b>76</b>
<b>Table 6.</b>	<b>Demographic Characteristics of Female Sex Workers (n=30)</b>	<b>89</b>
<b>Table 7.</b>	<b>Current Contraception Use of Female Sex Workers (n=30)</b>	<b>91</b>
<b>Table 8.</b>	<b>Demographic Characteristics of Female Sex Workers (n=30)</b>	<b>121</b>
<b>Table 9.</b>	<b>Number &amp; Living Situation of Children, per Woman (n=30)</b>	<b>122</b>
<b>Table 10.</b>	<b>List of Data Collection Instruments</b>	<b>158</b>

## Figures

<b>Figure 1</b>	<b>Reproductive Histories of Female Sex Workers (n=30) .....</b>	<b>90</b>
<b>Figure 2</b>	<b>Map of Tanzania, East Africa .....</b>	<b>149</b>
<b>Figure 3</b>	<b>Map of Iringa and Njombe Regions, Tanzania, East Africa .....</b>	<b>150</b>
<b>Figure 4</b>	<b>Map of Health Care Facilities in Iringa and Njombe Regions .....</b>	<b>151</b>
<b>Figure 5</b>	<b>Map of Iringa and Njombe Regions, with Major Highways and Study Sites .....</b>	<b>152</b>
<b>Figure 6</b>	<b>Venues: Vilabu or “Local Bars” (top, middle) and Ulanzi (Bamboo Wine) (bottom)....</b>	<b>153</b>
<b>Figure 7</b>	<b>Venues: Baa or “Modern Bars” .....</b>	<b>154</b>
<b>Figure 8</b>	<b>Venues: Grosari (Grocery) or Small Bars.....</b>	<b>155</b>
<b>Figure 9</b>	<b>Venues: Truck Stops .....</b>	<b>156</b>
<b>Figure 10</b>	<b>Venues: Guesthouses .....</b>	<b>157</b>
<b>Figure 11</b>	<b>Venues: Disco .....</b>	<b>157</b>

## List of Terms and Abbreviations

<i>Abbreviations</i>	<i>Explanation</i>
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
AOR	Adjusted odds ratio
Arusha	Town in northern Tanzania, also a region
ARVs	Anti-retroviral medications
Atlas.ti	Computer software for textual analysis
Bena	An ethnic group and language in southern Tanzania
CHACC	Council [Municipal] HIV/AIDS Control Coordinator
CHTC	Couples HIV Testing and Counseling
CI	Confidence Interval
DACC	District AIDS Control Coordinator
Dar es Salaam	Largest city in Tanzania, a port city on the east coast
Depo Provera	A brand name of an injectable hormonal contraceptive
DHS	Demographic and Health Survey
District	A governmental administrative unit, smaller than region and bigger than ward
Dodoma	The political capital of Tanzania; also a region
DRC	Democratic Republic of the Congo
FGDs	Focus Group Discussions
FHI360	Family Health International 360, an international NGO
FSWs	Female Sex Workers
GBV	Gender-based Violence
GoT	Government of Tanzania
HCWs	Healthcare Workers
Hehe	An ethnic group and language in southern Tanzania
HIV	Human Immunodeficiency Virus
HRW	Human Rights Watch
HTC	HIV Testing and Counseling
IBBS	Integrated Biological and Behavioral Survey
IDIs	In-depth Interviews
Ilula	A town in Kilolo District, Iringa Region, along the TanZam Highway
IRB	Institutional Review Board
Iringa	A region in southern Tanzania; also the principal town in the region
IUD	Intra-uterine Device, a form of contraception
Jhpiego	An international NGO
JHSPH	Johns Hopkins School of Public Health
Kilolo	A small town, the district capital of Kilolo (rural) District
Kinga	An ethnic group and language in southern Tanzania
KP	Key Populations in the HIV epidemic, including female sex

	workers, men who have sex with men, and people who inject drugs
KIIs	Key Informant Interviews
Mafinga	A town and urban district in Iringa Region
Makambako	A town and a district in Njombe Region
Mbeya	A town in western Tanzania, along the Tanzania-Zambia highway, and a region
MHSW	Ministry of Health and Social Welfare
Morogoro	A town in east-central Tanzania, along the Tanzania-Zambia highway, and a region
Moshi	A town in north-central Tanzania, in Kilimanjaro Region
Mufindi	A rural district in Iringa Region, surrounds Mafinga
MUHAS	Muhimbili University of Health and Allied Sciences, the national medical university, located in Dar es Salaam
Mwanza	Town in northwestern Tanzania, and a region
NACP	National AIDS Control Programme
NGO	Non-governmental Organization
NIMR	National Institute of Medical Research
Njombe	A region in southern Tanzania; also the principal town in the region
OC	Oral Contraceptive
OR	Odds Ratio
Pemba	An island off the coast of northern Tanzania, in Zanzibar
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PSI	Population Services International, an international NGO
Region	A governmental administrative unit, smaller than national and bigger than district
Sonagachi	A red-light district in Kolkata, India, site of a well-known, successful intervention for FSWs
Stata	Computer software for statistical analysis
STI	Sexually Transmitted Infection(s)
Swahili	Language widely spoken throughout Tanzania, Kenya, and other countries of East Africa
TanZam Highway	Major highway (one-lane each way) from the east coast of Tanzania to Zambia, with connections to Malawi and DRC, passing through Iringa and Njombe Regions
Tanzanian shillings (TZS)	Official currency in Tanzania; USD 1 = 1600 TZS during the study
TAZARA	Tanzania-Zambia Railway, runs from the east coast of Tanzania to Zambia, passing through Njombe Region
TGP	Theory of Gender and Power (by R.W. Connell)
Tunduma	A town in western Tanzania, on the border with Zambia
UNICEF	United Nations Children's Fund
USD	United States Dollar, USD 1 = 1600 TZS during the study



WHO	World Health Organization
Zanzibar	A group of islands off the coast of Tanzania which comprise a semi-autonomous region; also the principal town on the islands
<b><i>Swahili terms</i></b>	<b><i>English Equivalents</i></b>
<i>Aibu</i>	Shame, embarrassment; opposite of <i>heshima</i>
<i>Baa</i>	Bar, a large “modern” establishment that sells bottled beer, wine, and liquor as well as prepared foods
<i>Baamedii</i>	Barmaid, bar worker; can be derogatory; plural: <i>mabaamedii</i>
<i>Chama</i>	Association, club, guild, party; plural: <i>vyama</i>
<i>Changudoa</i>	Derogatory term for a woman with many sexual partners
<i>Dada poa</i>	Literally “cool sister” or “cool young woman”; a neutral or positive term used by sex workers for women who consciously exchange sex for money
<i>Grosari</i>	Medium-sized bar, from the English word grocery
<i>Heshima</i>	Respect, respectability, honor
<i>Hivi hivi</i>	Literally “just so” or “like this”; used to mean sex without a condom
<i>Hulka</i>	Character, e.g. moral character of a person
<i>Kahaba</i>	Derogatory term for a woman with many sexual partners; also <i>likahaba</i>
<i>Kiheshima</i>	With respect, respectably, like one who is respectable
<i>Kilabu</i>	Small bar that sells locally brewed alcohols such as <i>ulanzi</i> and <i>komoni</i> ; plural: <i>vilabu</i>
<i>Kimama</i>	Like a mother, motherly
<i>Kinga</i>	Protection, prevention, contraceptive; also an ethnic group; also a woman’s given name
<i>Komoni</i>	Locally brewed maize-based beer with 2-8% alcohol
<i>Kuanza dozi</i>	Literally “to start the dose,” e.g., to begin taking ARVs
<i>Kuchukia, kuchukiwa</i>	To hate, to be hated; used more often than <i>kunyanyapaliwa</i>
<i>Kuchukulia</i>	To treat, to consider, or to think about, as in, “What does the community think about FSWs?”
<i>Kudanganya</i>	To deceive, to trick
<i>Kudharua</i>	To despise, to insult; used more often than <i>kunyanyapaliwa</i>
<i>Kuficha</i>	To hide, hiding
<i>Kujificha</i>	To hide oneself, hiding oneself
<i>Kunyanyapaa</i>	To disgust, to loathe; also used as to stigmatize
<i>Kunyanyapaliwa</i>	To be stigmatized, to be loathed
<i>Kupenya</i>	To infiltrate, to penetrate; as in “the AIDS virus penetrates the cells”

<i>Kutenga, kutengwa</i>	To separate, to be separated; used more often than <i>kunyanyapaliwa</i>
<i>Kutongoza, kukutongoza</i>	To seduce, to seduce you; used to describe clients/sex workers picking each other up
<i>Kutulia</i>	To settle down; as in “to get married and settle down”; connotes a maturity that comes with age
<i>Liuza baa</i>	A mildly derogatory term for woman who works in a bar
<i>Madanguro</i>	Brothels; singular: <i>danguro</i> ; see Section 2.5.3
<i>Malaya</i>	Derogatory term for a woman with many sexual partners, often translated as prostitute
<i>Matatizo</i>	Literally, problems; a euphemism for HIV/AIDS
<i>Mavazi ya ajabu</i>	Shocking attire, e.g. the tight and revealing clothes sex workers may wear to attract clients
<i>Mgumba</i>	Barren, infertile person, a childless person
<i>Mhuni</i>	Deviant, also translated as prostitute
<i>Mwanamke anayebadilishana ngono kwa pesa</i>	Woman who exchanges sex for money; a direct translation from English, used by NGOs and researchers
<i>Mwanamke niliyekamilika</i>	I am a complete woman/ a woman who is completed
<i>Peku peku</i>	Naked; used to mean sex without condoms
<i>Salama</i>	Brand name of socially-marketed condoms; the name means “safe” or “peaceful”
<i>Udada poa</i>	Sex work; the abstract noun version of <i>dada poa</i> ; a neutral or positive term used by sex workers themselves
<i>UKIMWI</i>	AIDS; from <i>Upungufu wa Kinga Mwilini</i> (Immunodeficiency in the Body)
<i>Ulanzi</i>	A locally brewed wine, made from fermenting bamboo sap/juice; contains 5% alcohol on average
<i>Usiri</i>	Secrecy
<i>Vilabu</i>	Plural of <i>Kilabu</i>
<i>Vipimo vya UKIMWI</i>	AIDS tests, e.g. CD4 count, viral load
<i>Virusi vya UKIMWI</i>	HIV; literally, the AIDS virus, abbreviated VVU
<i>Vitenge</i>	A type of cloth worn as a wraparound; singular: <i>kitenge</i>
<i>Wahuni</i>	Plural of <i>Mhuni</i>
<i>Wahuni sana</i>	Very deviant people, very bad people
<i>Wanaofanya biashara ya ngono</i>	They who do sex work (trade/business)
<i>Wanawake wanaobadilishana ngono kwa pesa</i>	Women who exchange sex for money
<i>Wazi</i>	Open (literally and figuratively)

# **Chapter 1. Introduction**

## ***1.1 Study Objectives***

In public health and epidemiology, female sex workers (FSWs) are mostly studied for their HIV and sexually transmitted infection (STI) rates and risk factors, and interventions are aimed at lowering these. Even in places with generalized epidemics, such as sub-Saharan Africa, FSWs carry a disproportionate burden of risk. A recent meta-analysis calculated an adjusted odds ratio of 12.4 for FSWs compared to other women in the general population on the continent (Baral et al., 2012). While the national HIV prevalence was 5% in 2012 in Tanzania, prevalence was much higher in Iringa (9.1%) and Njombe (14.8%) Regions, where this study took place (Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), & ICF International, 2013). Studies among FSWs in Tanzania showed consistently high prevalence among FSWs, ranging from 19% to 68% (Ao, Sam, Masenga, Seage, & Kapiga, 2006; Riedner et al, 2006), and one study reported a 9-month incidence of nearly 14 per 100 person-years (Riedner et al., 2006).

The same behaviors that place FSWs at risk for HIV and STI can also place them at risk for unwanted pregnancy, but only a small body of literature has considered their reproductive health such as pregnancy histories and contraceptive use (Todd et al., 2010). There is an increasing amount of research on unintended pregnancy and abortion among FSWs (Decker et al., 2013). However, research on their desires for or experiences with

intended pregnancy are virtually non-existent, although it has been shown that some FSWs specifically seek pregnancy in work (Kerrigan et al., 2003; Wayal et al., 2011).

While there are many shared aspects of reproductive health among FSWs and other women of reproductive age, there are also unique dynamics to consider among FSWs due to the context of their work. For example, many FSWs have sexual relationships and co-parent with steady partners as well as clients, so there are multiple partnerships to consider (Murray et al., 2007). Particularly important among FSWs are possible links between pregnancy and HIV acquisition (Gray et al., 2005), transmission (Mugo et al., 2011), and disease progression (Lieve, Shafer, Mayanja, Whitworth, & Grosskurth, 2007). The potential relationship between hormonal contraception and HIV and STI is concerning, if not completely understood (Delvaux & Buvé, 2013), and is likely to disproportionately affect FSWs. Furthermore, FSWs are often stigmatized and face legal barriers (Ngugi, Roth, Mastin, Nderitu, & Yasmin, 2012; Scheibe, Drame, & Shannon, 2012; Scorgie et al., 2012), which can cause difficulties in accessing healthcare and receiving appropriate services (Scorgie et al., 2013). Although they are at high risk of HIV and unwanted pregnancy, services such as antenatal care (ANC), family planning, and prevention-of-mother-to-child-transmission (PMTCT) of HIV are rarely tailored to FSWs' needs.

In addition, little is understood about motherhood among sex workers, although data indicate that many FSWs begin sex work as mothers or because they are mothers (Basu & Dutta, 2011; Murray & MODEMU, 2002; Reed et al., 2012; Rivers-Moore 2010). Research gives some information about proportions of FSWs who have children,

ranging from 27% in Russia (Decker et al., 2013) to 90% in India (Reed et al., 2012), but any impact having and caring for children may have on their work lives and their HIV-related risk behaviors and health more broadly is not well understood. It may be that FSWs, when faced with the responsibilities of caring for their children, are less selective about partners, accept more clients, or agree to sex without condoms. They may be more likely to agree to a higher fee for unsafe sex compared to non-mothers, for whom earning money may not be as urgent. On the other hand, FSWs may strive to protect their health so they can stay alive as their children grow, provide for them, and see that they are educated. Thus there may be protective effects if these desires translate into safer sex.

As FSWs are generally women of reproductive age and thus experience both pregnancy and motherhood, but have unique dynamics and risks due to the context of their work, we aimed to explore some of these dynamics. The study objectives are to explore

- 1) FSWs' desires and experiences with intended pregnancy and access to ANC services;
- 2) FSWs' reasons for contraceptive use and their experiences with contraceptive services;
- and
- 3) intersections between motherhood, sex work and HIV-related risk among FSWs in the Iringa and Njombe Regions of southern Tanzania.

## ***1.2 Conceptual Framework***

We approach this study through two main frameworks, one implicit and one explicit: a socio-ecological approach and Connell's Theory of Gender and Power. First, there is an underlying assumption that people's abilities to achieve and maintain health

are affected by the contexts in which they live, that is, by factors beyond the individual. Various scholars give these contexts and factors different labels, such as “the social environment” or “structure.” Furthermore, the social environment has been delineated in different ways as multiple levels of influence and causation that impact health. These levels are explained in various socio-ecological models. For example, McLeroy, et al, recognized five levels of the social environment that determine health behavior: intrapersonal factors, interpersonal processes and primary groups, institutional factors, community factors, and public policy (McLeroy, Bibeau, Steckler, & Glanz, 1988). Sweat and Denison named four levels of causation that are especially important in HIV/AIDS prevention: superstructural, structural, environmental, and individual (Sweat & Denison, 1995). More recently, Baral, et al, proposed a socio-ecological model that stresses the importance of the stage of the HIV epidemic in addition to social factors (Baral, Logie, Grosso, Wirtz, & Beyrer, 2013).

Recognizing various levels is a helpful tool in both understanding HIV risk and in designing interventions. Any given level can interact with and influence other levels, e.g., lower levels of the model (e.g., individual) are impacted by the higher levels (e.g., structural) and vice versa. For example, whether or not a condom is used in a given sexual encounter between a female sex worker and her client is not simply a personal choice. Rather, it is influenced, for example, by the individual’s attitudes (does she trust condoms, or does he dislike them?); the nature of the relationship (is he a casual or regular client?); access to resources (are there condoms supplied at the bar and are they affordable?); laws (is sex work criminalized, and do police see carrying condoms as

“proof” of prostitution?); and the political economy (is she living in poverty, and did she migrate from home to look for work?). The various levels of influence require different types of interventions, and interventions that target multiple levels at once are likely to have greater impact (Baral et al., 2013).

The importance of the social environment operates implicitly throughout this study, and becomes explicit in Chapter 8 on Policy and Programmatic Recommendations. Additionally, the influence of the social environment is manifest in the stance this study takes toward sex work; it is the environments and structures in which sex work takes place, not the nature of sex work itself, that leads to HIV-related risk behaviors (Harcourt & Donovan, 2005; Pheterson 1989).

In addition to a multi-level, socio-ecological approach, this study also explicitly employs Connell’s Theory of Gender and Power (TGP) in Chapter 6 to better understand how motherhood impacts HIV-related risk among sex workers. First developed in 1987 but updated in 2002 (Connell 2002, 1987), the TGP provides a framework for analyzing gender relations in general. The TGP argues there are four structures or dimensions to gender—labor, power, emotional, and symbolic relations—which intertwine and reinforce each other to ideologically shape “women” and “men,” “masculinity” and “femininity” (Connell 2002; Maharaj 1995). Connell’s structure of labor refers to the “allocation of particular types of work to particular categories of people,” that is, “men’s work” and “women’s work.” The structure of power is the gendered divisions of “authority, control, and coercion.” The structure of emotional relations encompasses positive and negative affect, family, gender roles, attachments and commitments, as well

as sexuality. The fourth dimension of gender, symbolic relations, refers to meanings, the socially constructed interpretations of the gendered world (Connell 2002, 1987). These structures place constraints on members of society, but are (re)constituted through practice (1987), and are thus “vulnerable to major changes,” (Maharaj 1995) over time. That is, people have agency to act within their structures, and also to resist and change them.

This theory therefore lends itself well to analyze the case of HIV/AIDS, which is heavily influenced by structures of sexuality, power, labor, and meaning, as articulated in-depth by Wingood and DiClemente (2000). For example, these structures work in concert to “dictate[] appropriate sexual behavior for women...[and] constrain[] the expectations that society has about women with regard to sexuality” (2000), which has implications for sex work and for HIV. In turn, the TGP can be used to analyze a variety of institutional and socio-historical contexts (Maharaj 1995), such as motherhood and sex work in post-colonial Tanzania, which would be heavily influenced by, but nevertheless structured differently than, motherhood among other women in Tanzania. Unlike the socio-ecological models that have implicitly informed the research from its conception, we employed the TGP only after analysis of the data. We purposely postponed this incorporation of theory until late in the research process to allow themes to emerge from the data (Charmaz 2006). After the results revealed strong themes of gender, power, work, and meaning in sex workers’ lives, we chose the TGP as a relevant organizing framework to present the data in Chapter 6.



### ***1.3 Organization of the Dissertation***

This dissertation is organized into several Chapters. Chapter 2 presents and discusses the literature relevant to this study, including theoretical perspectives and epidemiology. This is followed by a discussion of existing research on the intersections of sex work, motherhood, and health. Chapter 2 continues with an introduction to the study setting. This describes key characteristics of the setting, such as the sex work venues, and a discussion of the terminology used in data collection, since the English and Swahili terms to describe sex work and sex workers are not exact translations. This chapter concludes with a discussion of the public health significance of this dissertation. Chapter 3 details the methods used to collect and analyze data.

Chapters 4 through 6 are each self-contained manuscripts detailing the findings of this study. Chapter 4 is entitled “*Do You Have a Husband?: Female Sex Workers’ Experiences with Intended Pregnancy and Antenatal Care Services in Southern Tanzania.*” This chapter explores women’s desires for and experiences with intended pregnancy in the context of sex work, and the barriers they face when accessing antenatal care. Chapter 5, entitled “*A Qualitative Exploration of Female Sex Workers’ Experiences with Contraception in Southern Tanzania,*” describes the unique challenges FSWs face with regards to contraception and accessing family planning services. Finally, Chapter 6, “*If You Have Children, You Have Responsibilities: Motherhood, Sex Work, and HIV in Southern Tanzania*” contextualizes motherhood by employing the Theory of Gender and Power, showing how motherhood both constrained and empowered women in their work, leading to both increases and decreases in HIV-related risk behaviors.

Chapter 7 summarizes the study findings, discusses strengths and limitations, and gives recommendations for future research, and Chapter 8 provides policy and programmatic recommendations. In Chapter 9 are the appendices, including maps, pictures of entertainment venues, and interview guides. Chapter 10 contains the bibliography.

## **Chapter 2. Relevant Literature and Study Setting**

### ***2.1 Theoretical Perspectives***

#### **2.1.1 Motherhood**

Motherhood is far more than biological reproduction of children; it is a concept, an institution (Akujobi 2011), and a social identity (Walker 1995). There is no consensus on what motherhood is or means, or on how to study it. In a review of North American scholarship on motherhood, Arendell saw three main categories in research on motherhood: activities (what mothers *do*), understandings (what it *means* to be a mother), and experiences (what mothers *feel*, such as satisfaction and distress) (Arendell 2000).

As a ‘facet of culture’ rather than a “fact of nature” (Sudarkasa 2004), motherhood in African societies is different than the North American motherhood which Arendell reviewed. There is limited scholarship on motherhood in Africa, mainly from West and South Africa (Akujobi 2011; Amadiume 1987a, 1987b; Nzegwu 2006; Oyewumi 2003; Sudarkasa 2004; Walker 1995). For example, Akujobi looked at motherhood in African literary discourse (though it was almost entirely limited to West Africa), and posited an “African motherhood” in which mothers are “blessed...respected and mythologized,” and that motherhood is necessarily desired by all women (Akujobi 2011). Though acknowledging the oppression of women and the control of the institution by men, this discourse also presents motherhood as empowering, powerful, and privileged (2011), a view that presents an African “motherism” as an alternative to Western “feminism” (Walker 1995). This is reflected in the anthropologist Amadiume’s writing as well; she used the Igbo in Nigeria to argue that they, and indeed all Africans, once “enjoyed

matrifocality,” where women, as women and as mothers, played a central role not just in reproduction, but also the economy, politics, and inheritance (Amadiume 1987b).

Walker (Walker 1995) explored the case of South African motherhood, and described three “interrelated terrains” of motherhood: practice, ideology, and social identity, which loosely echo Arendell’s categories. Walker showed that motherhood is also heavily influenced by historical as well as cultural factors; in South Africa, then, the history of apartheid and the nature of the mining industries have structured motherhood there. In one study where motherhood is related to HIV, Iwelunmor, et al, emphasized motherhood as a lifelong commitment and explored the impact this had on HIV disclosure by mothers and to mothers in South Africa (Iwelunmor, Zungu, & Airhihenbuwa, 2010).

In another approach to African motherhood, Guyer explored the “logic of polyandrous motherhood” among the Yoruba in Nigeria. She argued that parental rather than marital ties are the strongest socially; marriage dissolves and people informally or formally remarry, but parents are always parents. Thus, a “logic” of reproduction is that children expand parents’ social networks. That is, “particularly to women, children can be a means of creating new ties for oneself in a lateral strategy of network-building, giving opportunities for political and social mobility.” Through her children, a woman can make claims to inheritance, property and social capital, even long after her sexual relationship with the father ends (Guyer 1994). Motherhood, then, can be seen as a strategy, and bearing children with multiple men (“polyandrous motherhood”) can be advantageous to women, in that they can claim access to more social and physical capital.

This logic entered Haram's analysis of single mothers in Tanzania. Women who may be considered sex workers to outsiders saw themselves as single mothers trying to make ends meet by strategically entering and exiting partnerships with men, including fathers of their children. Motherhood was also considered essential to womanhood, adulthood, and respectability (Haram 2003). Supporting Akujobi's analysis of motherhood in African literary discourse, other scholars have argued that motherhood is a requirement for womanhood in Tanzania. Hollos and Kielmann spoke of the pain and social stigma their participants felt due to infertility and not being able to fulfill their expected roles as mothers in Pemba and Moshi, Tanzania, respectively (Hollos & Larsen, 2008; Kielmann 1998). Allen wrote of the vital importance of motherhood to women in a region bordering the study site. In that context, women were far more concerned about "risks *to* motherhood," such as becoming infertile or not being able to produce a healthy baby for the paternal lineage, than they were about "risks *of* motherhood," such as maternal morbidity and mortality, which concern public health practitioners. Proving fertility by producing children thus took precedence over the mother's health, for both the mother herself and for the husband and his family (Allen 2002). Motherhood's relationship to sex work and HIV are explored further below.

### **2.1.2 The Political Economy of Sexuality**

Beginning in the 1990s, scholars such as Parker have argued that sexual encounters must be understood within the "complex set of social, structural, and cultural factors" in which they occur, including the "differentials of power[ ] particularly between men and women" (Parker, Barbosa, & Aggleton, 2000). In this, the forces of

globalization and the neoliberal market economy are key. Globalization is necessarily shaping sexual relationships and the meanings ascribed to them (Altman 2002). It is structural factors, such as “substantial economic hardship and uncertainty” in daily life, not “exotic cultural practices” that lead to HIV transmission (Schoepf 1992). In this political economy of sexuality and of love, gendered power relations (along with race, class, and globalization) are analytic tools to understand how “sexual inequality” limits “the potential for negotiation in sexual interactions and, in turn, condition the possibilities for the occurrence of sexual violence, for patterns of contraceptive use, for HIV/AIDS risk reductions strategies, and so on” (Parker & Easton, 1998).

The economic forces of capitalism are thus at play, and in the structures of gender inequality where men hold the money and the power, “sex is one commodity” among others, used by women to bargain with those “more wealthy or more powerful” (Preston-Whyte, Varga, Oosthuizen, Roberts, & Blose, 2000). One’s sexual services and abilities are used variously as a way to get visas or trips abroad (Brennan 2007); money for survival (Cheng 2007; Preston-Whyte et al., 2000); or love and attention (Padilla, Hirsch, Munoz-Laboy, Sember, & Parker, 2007). That sex can be traded implies it has value; sex becomes a “means of production” (Altman 2002). Sexual exchange was seen as normative in South Africa, resulting in women having multiple partnerships, thus increasing their risk for HIV (Leclerc-Madlala 2003). This is particularly risky for women, who more often lack negotiating power in these types of relationships and encounters (Parker & Easton, 1998).

Economic liberalization and globalization have led to economic inequality and the feminization of poverty in much of the world, including in Tanzania. Setel argued that HIV was perceived as a disease of the rich in northern Tanzania, because if a man had money, he could pursue many partners. Women, on the other hand, could most easily access the commodities of modernity through having sex with richer men (Setel 1999). In this way, it was inequality—the coexistence of both wealth and poverty—that drove the epidemic. In another study of rural adolescents and their parents in Tanzania, young women—and their mothers—considered themselves lucky to have their bodies as “goods” they could exploit for both “pleasure and material gain” (Wamoyi, Fenwick, Urassa, Zaba, & Stones, 2011). A Dar es Salaam-based study found similar dynamics. Money and other goods were exchanged in all types of sexual relationships, whether casual or long-term; women expected money and goods from partners, and either added other partners or broke off relationships when men could not economically perform (Maganja, Maman, Groves, & Mbwambo, 2007). Haram, building on years of ethnographic work in northern Tanzania, thus argued that it was not the exchange of sex for money per se that violated social norms in Tanzania; rather, it was public acknowledgement or flaunting of extramarital relationships that was condemned and brought “shame” (to the women, not the men). As long as people (especially women) maintained secrecy in their sexual relationships, they maintained respectability (Haram 2005).

## ***2.2 Epidemiology of HIV among Female Sex Workers in Tanzania***

In 2012, the Iringa and Njombe Regions of southern Tanzania (see Figure 3 in Appendix 1) had the highest HIV prevalence in the country, at 9% and 14.8%, respectively. The prevalence was higher than in Dar es Salaam, the largest city and economic capital (7%) and more than double the national average (5%) (Tanzania Commission for AIDS (TACAIDS) et al., 2013). Transmission of HIV in Tanzania was largely due to heterosexual contact (National Bureau of Statistics 2011), and women in these regions had a significantly higher HIV prevalence than men (Iringa 11% vs. 7%; in Njombe 15% vs. 14%) (Tanzania Commission for AIDS (TACAIDS) et al., 2013). It is unclear why Iringa and Njombe had higher prevalence, but it may be partly due to the numerous plantations in the regions, which attract migrant and seasonal workers. In addition, a major transport corridor, the Tanzania-Zambia highway, cuts through the regions, and brings long-distance travelers to the numerous guesthouses, bars, and truck stops where female sex work occurs.

Even in countries with generalized epidemics, female sex workers carry a high burden of risk. In sub-Saharan Africa FSWs have 12.4 times higher odds of having HIV than other women in the general population (Baral et al., 2012). In Dar es Salaam, Tanzania, HIV prevalence among FSWs was approximately 30% in 2010 (National AIDS Control Programme 2012). There were recent efforts to estimate prevalence among FSWs in Iringa town, but data were not available at the time of writing (personal communication, Population Services International staff, November 2013). Earlier studies by the Government of Tanzania estimated HIV prevalence among FSWs in towns and



truck stops was as high as 60%, and the prevalence among bar workers was somewhere between 32% and 50% (National AIDS Control Program 2005).

The peer-reviewed literature on FSWs in Tanzania focused largely on female bar and hotel workers. A study of over 1000 bar workers in Moshi in northern Tanzania found an HIV prevalence of 19% (Ao et al., 2006), while a smaller study (n=312 bar workers) in the same area measured prevalence at 26% (Kapiga et al., 2002). In a mining town in northwest Tanzania, 42% of female food and recreational workers were infected with HIV. In contrast, 68% of bar and hotel workers had HIV in Mbeya (southwestern Tanzania) (Riedner et al., 2006). Other STI were also highly prevalent. For example, HSV-2 ranged from 43.5% in northwest Tanzania to 80% in north-central Tanzania (Kapiga et al., 2003; Watson-Jones et al., 2007).

Among FSWs in Tanzania, HIV was associated with older age; younger age at sexual debut; mobility; alcohol use; hormonal contraception use; gonorrhea; and being formerly married (Ao et al., 2011; Ao et al., 2006; Fisher, Cook, & Kapiga, 2010; Tassiopoulos et al., 2007; Watson-Jones et al., 2009, 2007). FSWs in Tanzania, as elsewhere, experience high levels of stigma and discrimination as well as physical and sexual violence from community members, sexual partners and state actors such as police (Decker et al., 2010; Human Rights Watch & WASO, 2013; Renzaho & Pallotta-Chiarolli, 2009).

### ***2.3 Epidemiology of Sex Work and Reproduction***

While most epidemiological research on FSWs is concerned with HIV, STI, and their predictors and correlates, in the past few years some attention has turned to FSWs' reproductive health more broadly. See Table 1 for statistics on reproductive histories of FSWs. A study conducted by Todd, et al, (2010) is the most comprehensive, reporting on several pregnancy indicators for three separate sites in Afghanistan, including proportions ever experiencing pregnancy (82%), mean number of pregnancies (2.8-4.45), mean number of live births (3.38-4.25), proportions with prior miscarriages or stillbirths (14-26%), proportions with prior unplanned pregnancies (20-60%), as well as abortion rates (27-55%). Decker, et al, also reported on contraceptive use and abortions among FSWs. Of 147 FSWs in Russia, 58% reported at least one abortion; 12% reported a modern method of contraception other than condoms; and 70% had ever been pregnant (2013). Wayal, et al, reported similarly high rates of ever having been pregnant (91%) in India, and also found that 18% were *planning* a pregnancy (one-third of these planners were HIV-positive), and an additional 2% were currently pregnant (2011). While lifetime pregnancies tells nothing of the timing of the pregnancy with regard to initiation of sex work, Decker, et al, report that nearly 9% of their sample had become pregnant since entry into sex work (20% among the women who had been trafficked) (Decker, McCauley, Phuengsamran, Janyam, & Silverman, 2011).

Data on pregnancy rates among FSWs is sparse for African countries. Feldblum, et al, measured incident pregnancy in a cohort of 935 FSWs in Madagascar. By the end of the 18-month follow-up, 250 (27%) had become pregnant. Note that these pregnancies

occurred while enrolled in an intervention to promote condom use (Feldblum et al., 2007). In a northwest Tanzania study, almost 7% of women working in bars and guesthouses were currently pregnant (Watson-Jones et al., 2009). Other studies have focused on FSWs' use of contraception to prevent unwanted pregnancy as well as rates of pregnancy termination. Such studies are rare in the African continent, however, and contraception and termination are generally not the primary focus when they are reported. For example, an STI intervention study from Mbeya, Tanzania mentioned measuring contraception and pregnancy, but reported no results on either (Riedner et al., 2003). Another study in northwest Tanzania focusing on risk factors related to HIV reported on contraceptive use as just one of many risk factors (59% were currently using hormonal contraceptives) (Watson-Jones et al., 2009).

Many sex workers are also mothers. It was estimated that over two-thirds of FSWs in sub-Saharan Africa have children (Scorgie et al., 2012), and global estimates seem to not exist (Beard et al., 2010). Two different studies in northern Tanzania found FSWs had three children on average (Nkya et al., 1991; Renzaho & Pallotta-Chiarolli, 2009), and an additional study reported that 70% of bar workers had at least one child each (Akarro 2009). In Kenya, one study found 90% of FSWs had dependent children (Elmore-Meegan, Conroy, & Agala, 2004), while another reported 82% had children at home, with a mean of 3.4 children per woman (Chege, Kabiru, Mbithi, & Bwayo, 2002). Outside of Africa, the percent of FSWs reporting at least one child ranged widely: 27% in Russia (Decker et al., 2013), 51% in Afghanistan (Todd et al., 2010), 85% in Colombia (Bautista et al., 2008), and 90% in India (Reed et al., 2012).

There are many gaps in the epidemiological literature about sex work and reproduction. For example, little is known about whether these pregnancies came before initiation of sex work (see above for two exceptions), or if they came from clients or regular partners. Kerrigan, et al, asked FSWs if they wanted to have a child with their most recent regular, paying client; many said yes (Kerrigan et al., 2003). Half of the women interviewed in a Tanzania study had at least one child of unknown paternity (Renzaho & Pallotta-Chiarolli, 2009), but it is unknown what effect partner type might have on the mother or birth outcomes. Research on the maternal health of FSWs specifically, such as access to care, utilization of antenatal care, and maternal morbidity and mortality seems to be absent.

#### ***2.4 Motherhood, Sex Work & HIV***

Scholarship that connects motherhood and sex work is rare, although motherhood and sex work intersect and do so in complex ways. A few studies have suggested that financially supporting children is a major incentive for women to participate in sex work, where they may be able to make more money than they would in other jobs available to them (Kerrigan, Moreno, Rosario, & Sweat, 2001; Mbonye et al., 2012; Reed et al., 2012; Scorgie et al., 2012; Zalwango et al., 2010). Some researchers showed that many female sex workers begin sex work as mothers or *because* they are mothers (Basu & Dutta, 2011; Delacoste & Alexander, 1987; Murray & MODEMU, 2002; Rivers-Moore 2010; Zalwango et al., 2010). Others showed that sex workers sometimes specifically seek child bearing (Kerrigan et al., 2003; Wayal et al., 2011), perhaps as a way to leave sex work by securing a relationship with the father, or at least the father's financial and/or emotional

attention (Haram 2003; Murray & MODEMU, 2002). Classic writings on sex work made numerous mentions of the existence of sex workers' children, but rarely discussed how motherhood and sex work interrelate (Delacoste & Alexander, 1987; Pheterson 1989).

There are a handful of studies that explore the experiences of sex workers as mothers. A common theme across these studies was a struggle over identity as mothers, and a desire to justify their stigmatized work as “for the children.” Castañeda, et al, argued that mothers in Mexico faced a “societal schizophrenia” in which they lived both as “mother” and “prostitute” in a society that did not accept that one person could be both. Thus, women created a divide between work and home life, separating the social and sexual relationships that belonged in each sphere (Castañeda, Ortiz, Allen, García, & Hernández-Avila, 1996). Similarly, in the Dominican Republic, Kerrigan, et al, found not a duality but a continuum separating “street” and “home,” where condom use was more common in “street” relationships, but less common in “home” relationships, which were characterized by family (and children) (Kerrigan et al., 2001). Similarly, in Costa Rica, FSWs justified their work to themselves and others as “for the children,” giving them commodities and opportunities they themselves may not have had as children. In this context, “motherhood is central to sex workers’ ability to combat stigma” in that they could emphasize their roles as mothers/providers forced into difficult circumstances they might have not chosen otherwise (Rivers-Moore 2010). In India women reported entering sex work in order to take care of their children in a context of few job opportunities for uneducated women. These women desired better education for their children so they might escape poverty. Thus, women collectively constructed their identities as “mothers

first,” and not as the “incapable mothers” that mainstream narratives constructed for them. Rather, these mothers wanted to be healthy and safe in order to be there for children in the long term (Basu & Dutta, 2011).

Studies about mothers who were sex workers in the US seem to be limited to women who worked on the streets. In one study in the US, nearly 90% of street sex workers had children, but the children most often did not live with their mothers due to drug use. Nevertheless, the mothers reported caring for their well being, visiting them, and wanting what was best for them, and cited having the children as their single best experiences in life (Bletzer 2005). Another US study found that FSWs’ strongest motivation to improve their lives came from their children; 88% of them were mothers (Dalla 2001). In another US study, authors explored how being mothers directly affected sex work. When women became pregnant, for example, they had to adjust how often they worked, especially in the later stages of pregnancy (some continued to work throughout). Women constantly worried about having to leave their children to work, and worried about being hospitalized, jailed, or killed on the streets, and leaving their children motherless. Sex workers with children thus faced all the stress of the job, plus the stress of parenting (Sloss & Harper, 2004).

There are several possible ways in which motherhood might be associated with HIV-related risk behaviors. Some FSWs reported striving to protect their health, so they could keep healthy and stay alive as their children grew (Basu & Dutta, 2011). Others reported having strong senses of identity as mothers, saw their children as the most important things in their lives, and were proud to be able to provide for their children and

give them brighter, educated futures (Basu & Dutta, 2011; Murray & MODEMU, 2002; Rivers-Moore 2010). Thus there may be protective effects if these desires translate into safer sex. On the other hand, some FSWs reported having to choose between safe sex or going to a health clinic for STI check-ups on the one hand and earning money to feed their children on the other (by increasing the number of partners or agreeing to unsafe sex) (Basu & Dutta, 2011). It may be that FSWs, when faced with the responsibilities of caring for their children, are less selective about partners, accept more clients, or use condoms less consistently. They may be more likely to agree to a higher fee for unsafe sex compared to non-mothers, for whom earning more money may be not as urgent.

Only one published study found to date has measured a concrete impact of motherhood on HIV-related risk behaviors. Reed, et al, measured “challenges of motherhood” (three or more children in the household; children under five years on the household; child’s recent illness) to predict certain HIV-related risk behaviors (consistent condom use; accepted more money for sex without condoms; recent history of STI) among FSWs in India. They found that sex workers who had three or more children in the household were 40% less likely to report consistent condom use (AOR: 0.6, CI: 0.4-0.9). The authors suggest two possible mechanisms in which motherhood affected issues like condom use. One, it could be the financial burden of supporting children that led to behaviors like accepting more money, despite the health risks. Two, it could be that they had less time to work because of the demands of caretaking, and so accepted “riskier sex trades.” Since the total number of sex trades was not different between women “with and without greater caretaking demands,” the authors believed it could be that women

“maximize financial gains from each sex trade engagement, resulting in increased reports of unprotected sex trades, rather than an increase in number of sex trades reported” (Reed et al., 2012).

The Sonagachi Project in Kolkata, India is an example of an intervention that supported both sex workers and their children. In this red light district, FSWs have mobilized to form an active community, approaching HIV risk as an occupational health problem (Jana, Basu, Rotheram-Borus, & Newman, 2004). FSWs have kept HIV rates low in the community with their “multifaceted, multilevel interventions addressing community, ...group, ...and individual factors” (Jana et al., 2004). The key role motherhood played in FSWs’ lives was brought starkly to the attention of the intervention when FSWs attending newly opened STI clinics reported their “primary issue in life was the problem of conceiving children” (Jana et al., 2004); that is, they worried about the inability to become mothers more than they worried about HIV, for example. Thus, the Sonagachi Project incorporated mothers’ and children’s needs into the project, especially focusing on access to education and healthcare for the children, which had largely been denied them (Jana et al., 2004). In another Indian case, a 24-hour shelter/crèche for sex workers’ children operates. There, it was recognized that motherhood “entailed a daily struggle to provide basic necessities for their children” and that by providing resources for their children, the intervention “reduced the pressure on sex workers to earn money at all cost,” such as having sex without condoms for more money (Basu & Dutta, 2011).



## **2.5 Study Setting**

### **2.5.1 Location, Population, and History**

This study took place in two regions, Iringa and Njombe, in the Southern Highlands of Tanzania in East Africa (see Figure 3 in Appendix 1). When this study was planned, Iringa Region was one of 26 administrative regions in Tanzania, but over the course of the research, the region was divided into two regions, Iringa in the north and Njombe in the south. Four of the five study sites were in districts of the new Iringa Region (Iringa Municipality, Kilolo, Mafinga Municipality), and one in Njombe Region (Makambako). The most recent Demographic Health Survey (DHS) (National Bureau of Statistics 2011) was published before the division, and the most recent Tanzanian HIV/AIDS and Malaria Indicator Survey (THMIS) was published after the division (Tanzania Commission for AIDS (TACAIDS) et al., 2013); thus, some statistics are for the old region as a whole, while some data are available separately.

Iringa Region had a population of nearly 950,000, and Njombe Region of about 700,000 according to the 2012 census (National Bureau of Statistics & Ministry of Finance, 2013). The main ethnic groups in the regions are the Hehe, Bena, and Kinga; the respective languages are the first languages of most people, but inhabitants also speak Swahili, the national language. Germany first colonized what is now mainland Tanzania in the 1880s, and the colonists adopted Swahili as the language of administration, uniting more than 120 ethnic groups under the common language (Iliffe 1979). The Hehe, who inhabit most of the study area, are known for their fierce resistance to the colonizers in the 1890s German-Hehe War under the leadership of Chief Mkwawa (Pizzo 2007). A museum and monument to the resistance movement stand a few kilometers west of town,

proudly featuring the skull of Chief Mkwawa, who shot and killed himself rather than be captured. The British took over the area known as Tanganyika during World War I as a League of Nations mandate. The nation gained independence peacefully in 1961 under the leadership of Julius Nyerere; Tanganyika later united with Zanzibar to become Tanzania in 1964 (Iliffe 1979).

Since colonies like Tanganyika and Zanzibar had been designated as sources of raw materials for the industrialized north, independence left most of the former colonies economically underdeveloped, under-resourced, and with poor telecommunications and transport infrastructure (Shillington 2005). Beginning in the late 1960s, Nyerere envisioned and began to implement an “African socialism” in Tanzania, called *ujamaa*, characterized by rural development, nationalization of industry and banks, an emphasis on self-reliance, and “villagization,” the forced removal of existing smaller villages to larger ones along transport corridors. Although *ujamaa* was abandoned in the late 1970s, and Tanzania remained one of the poorest African countries through the 1980s, Tanzania did succeed in implementing a universal healthcare system and other social services (Shillington 2005). Though understaffed and undersupplied, healthcare centers and dispensaries are spread throughout Tanzania, with a facility within a few kilometers of every village (See Figure 4 in Appendix).

The financial difficulties of the 1980s in Tanzania, as in many countries in Africa, led to the structural adjustment programs (SAPs) of the International Monetary Fund (IMF) and World Bank. This resulted in forced spending cuts on social and health services, among other conditionalities that further hurt Tanzania’s economy and social

welfare (Shillington 2005). The 1980s also marked the beginning the AIDS crisis; the first cases of AIDS were diagnosed in 1983 in northwest Tanzania and HIV was reported in all regions by 1987 (Tanzania Commission for AIDS (TACAIDS) et al., 2013). The 1990s through the present have been characterized by globalization, neo-liberal capitalism, privatization, and increasing income inequalities (Chazan 1999; Tsuruta 2006) and the continued spread of HIV/AIDS. In 2013, around 1.6 million Tanzanians were living with HIV/AIDS, with more than 600,000 on antiretroviral medications (TACAIDS et al., 2013).

Tanzania's historical trajectory also undoubtedly had a profound effect on gender structures (e.g., the introduction of Islam, the Indian Ocean trade, pre-colonial life, the slave trade, the Christian missionary movement, colonization, two world wars, independence, post-colonialism, structural adjustment, globalization, and the HIV epidemic) (Iliffe 1979; Shillington 2005). Chapter 6 outlines the structures of gender at the time of the study, but it should be noted that gender as a social structure changes over time as it is (re)constituted through practice. Indeed, Connell emphasizes its historicity (Connell 1987). Amadiume makes a case for the changing nature of gender from pre-colonial times to the 1980s among the Igbo in Nigeria, and asserts that similar processes occurred throughout Africa (Amadiume 1987b). Similarly, Tanzania's history has influenced the current practice of motherhood and sex work. For example, it is reasonable to assume that indigenous cultural practice, Christianity, the colonial introduction of the cash economy, globalization, and the HIV epidemic have impacted social norms in general and gender structures specifically, including motherhood and sex work. That

women in this study referred to husbands/fathers as breadwinners and wives/mothers' place as in the home speaks as much to missionary Christianity as to "African tradition," if not more so (Amadiume 1987b; Comaroff & Comaroff, 1991).

### **2.5.2 The TanZam Highway**

An important element of the study site was the Tanzania-Zambia ("TanZam") highway. It runs from Dar es Salaam, the commercial capital on the east coast, through central Tanzania, before crosscutting Iringa and Njombe Regions (see Figure 5 in Appendix 1), then continues on to Zambia, Malawi, and the Democratic Republic of the Congo (DRC). Another highway splits off the TanZam highway within Njombe Region and heads south to Mozambique. The highway is landlocked Zambia's major transport corridor; the overland journey there along this two-lane tarmac road takes several days for transport workers; thus there are guesthouses, bars, restaurants, petrol stations, weigh stations, and truck stops in the larger villages and small towns throughout the route. Many of these stops also serve as sex work venues, and truckers comprise a large portion of FSWs' clientele.

Four of the five study sites rest directly along this highway, between 450 and 600 kilometers from Dar es Salaam (see Figure 5 in Appendix 1). Those four study sites share commonalities because of their location on the highway, but are also distinct. If driving the highway from Dar es Salaam, Ilula is the first of the locations in the study. Ilula, in Kilolo District, had a population of about 25,000 (all population figures in this section are from the 2012 census: National Bureau of Statistics & Ministry of Finance, 2013), and has a large, popular truck stop area. It is heavily dependent on seasonal tomato markets.

Approximately 60 kilometers off the highway to the south on a dirt road is Kilolo, a small district capital with one kilometer of tarmac road. Kilolo plus the surrounding villages had a population of about 11,000. Back along the highway Iringa town comes next. It is the regional seat of government and the site of the German military fort during the German-Hehe War. From Iringa, dirt roads split off north to Dodoma, the national political capital, and west to Ruaha National Park. Thus, Iringa town, population 150,000, is a hub, a place to stop on the way to somewhere else for tourists and truckers alike, but also hosts several universities, factories, and markets. Now heading south along the highway, the next town is Mafinga, in Mafinga Municipality District, with a population of about 52,000. The town's economy depends on the area's multiple tea and timber plantations. Further south still is Makambako, with a population of 94,000; it is the seat of the newly formed Makambako District in Njombe Region. Makambako is a major crossroads; here, the highway splits. One road continues south to Ruvuma Region and ultimately Mozambique; the TanZam highway continues toward Zambia, Malawi, and the DRC. The Tanzania-Zambia Railway (TAZARA) also passes through Makambako, connecting it to the sugar plantations in Morogoro Region to the northeast, and rice and coffee plantations in Mbeya Region to the west.

### **2.5.3 Venues**

There are different types of entertainment venues in the area, each type different in the socioeconomic status of both sex workers and clientele found in them, as was also found in northwest Tanzania (Shagi et al., 2008). This study distinguished between four main types: *vilabu*, *baa*, *grosari*, and truck stops. We use the Swahili names because,

while they all could be translated simply as “bar,” they are distinct and attract different clientele. See the pictures in Appendix 2 for examples of venues. (Note that the pictures in the Appendix are *not* sites where we recruited women for this study, but rather represent the types of places where sex workers may seek clients.)

*Vilabu* (singular: *kilabu*, from the English word “club”) are small, often informal bars that sell locally made alcohol such as *ulanzi* (bamboo wine), *komoni* (maize beer), and other grain-based alcohols. See Figure 6 in Appendix 2 for examples of *vilabu* and a picture of *ulanzi*. *Ulanzi* is especially popular in Iringa and Njombe Regions, and every village has several bamboo groves and a few *vilabu*. Sweet, cloudy-white *ulanzi* is consumed by the liter, which costs around 500 shillings (30 cents), and has about 5% alcohol content, while *komoni* is also cheap and ranges from 2-8% alcohol content (Willis 2002). The rainy season (January through May) is also the *ulanzi* season, and people associate the time with drunkenness, casual sexual encounters, sexually transmitted infections, and unplanned pregnancies. *Vilabu* may also sell bottled beer and food, but there are known for their local brews. A *kilabu* can be in a woman’s house, in a one-room store front, or on makeshift benches under a shady tree. It can also be a busy neighborhood where 20 or more women each sell their own brews from buckets in individual stalls.

*Baa* (plural *mabaa*), from the English word “bar,” are generally large establishments that sell bottled beer and liquor, and perhaps roast meat and other basic dishes, and may or may not be connected to a guesthouse and/or provide rooms for short-time rent. See Figure 7 in Appendix 2. The distinctions between *mabaa* and *vilabu* date to

colonial times, when bottled beer was exclusively for white colonists' use, while local brews were for East Africans (Willis 2002). Today, bottled beer is more expensive than local alcohol, so the clientele of *mabaa* tend to have more money, both for drinks and for sexual services. While a *kilabu* may sell bottled beer, a *baa* never sells local brews.

*Grosari*, from the English word grocery, are small bars that sell alcohol, both bottled and local, and usually also some prepared foods (see Figure 8). The distinction between *grosari* and other types of bars are sometimes simply semantic. While usually spelled *grocery* in Swahili, we use a phonetic spelling of *grosari* here in order to distinguish them from grocery stores as understood in English; *grosari* are in no way suppliers of groceries. Truck stops (see Figure 9) are along strips of highway that can be several hundred meters long, and include several alcohol venues as well as guesthouses (see Figure 10). Some FSWs were employed in specific venues at truck stops, while others were independent, directly approaching men in or near their trucks.

In this study, female employees at venues sometimes sold sex to supplement their low monthly salaries (in *mabaa*, often 20,000 Tanzanian shillings, about USD12). Other sex workers patronized all the above venue types as well as discos (see Figure 11) to find customers, but without being employed there. Many of these latter workers adopted the term *dada poa* (see Section 2.5.5 below). It should be noted that this study as well as the study in which it was embedded found that sex work in Tanzania was characterized by independence; each sex worker worked for herself, and was not required to give a percentage of her earnings to anyone. While a woman may have earned a salary at a bar, the salary was for her work within the bar, such as serving food and drinks to customers.

Any arrangement she made with a customer there was between her and the man; they alone determined price, sex acts, and where and when to meet.

During the study, reports surfaced of an additional type of sex work venue called *madanguro* (singular: *danguro*) which was previously unknown to the study team. The dictionary translation of this term is brothels, but little is known how they operate. A sex work activist in Dar es Salaam explained that *madanguro* are buildings where many women rent rooms that they use both as living quarters and places to entertain clients. The activist explained that each woman operates independently, and while she pays rent to the owner, she keeps all other earnings for herself. A similar type of work environment was described in Morogoro town (Outwater et al., 2001). No women who worked in *madanguro* were interviewed in this study.

#### **2.5.4 Interventions for Sex Workers in the Study Sites**

Interventions targeting FSWs were limited in the area. A variety of male condoms were commercially sold in retail shops and pharmacies, especially along the highway. Certain brands of condoms were sold at subsidized prices through social marketing programs, in particular through Tanzania Marketing and Communications (T-MARC) and Population Services International (PSI). PSI's Salama brand was so well known that sex worker participants sometimes referred to condoms as simply Salama. Some entertainment venues also had condoms available for sale, and many health centers also kept boxes of condoms in waiting rooms, etc. for free. Two brands of female condoms, one free and one for purchase, were also available, but were rare compared to the male condoms.



During the time of data collection, T-MARC and PSI ran a program that promoted condoms in truck stops that entertained a high volume of overnight guests along the TanZam highway. After data collection was complete, PSI began another program targeting FSWs with HIV counseling and testing and peer-to-peer linkages to HIV care. A baseline Integrated Biological and Behavioral Survey (IBBS) using respondent-driving sampling among 220 FSWs in Iringa town was conducted in mid-2013 as part of this program; results were unavailable at the time of writing but were expected in 2014 (personal communication with PSI staff, November 2013).

Additionally, FHI360 ran a program in Ilula and Makambako in part targeting economically vulnerable women, including some sex workers. This program distributed condoms, educated about HIV/AIDS and family planning, and supported economic strengthening. Finally, Jhpiego-Tanzania conducted HIV testing and counseling (HTC), post-test counseling, linkages to care, and gender-based violence (GBV) screening and services among high-risk populations, including bar-based FSWs, in Iringa town.

At the time of writing, Tanzania's Ministry of Health and Social Welfare (MHSW) was drafting a national strategic plan to address HIV/AIDS among key populations at risk, including female sex workers.

### **2.5.5 A Note on Terminology**

The term "sex worker" can encompass a broad range of people and their activities, and it is not sex work itself that is risky. Rather, it is the environment and structures in which sex work takes place that determine, for example, FSWs' abilities to insist on condom use. Harcourt and Donovan provided an exhaustive list and

descriptions of types of sex work around the world. The authors argued that different types of sex work have “different degrees of health and safety risk” (Harcourt & Donovan, 2005). Specifically, where sex work is criminalized, as in Tanzania (Government of the United Republic of Tanzania 1981), where the women are poorer, or where they are forced to have many partners, sex workers face higher health risks (Harcourt & Donovan, 2005).

Furthermore, sex work can be criminalized in different ways. Our review of the Tanzanian penal code of 1981 revealed that it does not specifically prohibit exchanging sex for money, nor does it concentrate on actions done by the sex workers themselves. Instead, it prohibits actions associated with brothel owners/managers and pimps (allowing prostitution to occur in an establishment; detaining a woman against her will for purposes of “unlawful carnal knowledge,” etc.) (Government of the United Republic of Tanzania 1981). A later act, the Sexual Offenses Special Provisions Act of 1998, also prohibited “procurement (with or without consent) for sex work or sex trafficking to or from Tanzania” (Betron 2008).

“Sex worker,” though used here for simplicity and clarity (and to declare a certain philosophical stance [Delacoste & Alexander, 1987]), was not an identity or label which women used for themselves. Words from Swahili that are most often translated into English as “prostitute” generally mean women (or men) who have many sexual partners in an indiscriminate or unselective manner (rather than people who exchange sex for money). They include *mhuni*, *malaya*, *kahaba*, *liuza baa* and *changudoa*. All these terms are derogatory, and should be translated as “whore” to match the offensive nature of the

words, and to indicate that the insult is intended to refer to the fact of multiple partners, rather than monetary exchange. In Mwanza, Tanzania, for example, community members defined “prostitution” (*umalaya*) as accepting any and all sexual partners, not the act of accepting money from those partners. Indeed, monetary exchange for sex has been found to be normative, widely tolerated, and expected in Tanzania, including by parents whose children engaged in it (Tomori et al., 2013; Wamoyi et al., 2011). Participants in this study were aware of the derogatory terms, but never used them to refer to themselves.

The phrasing used in recruitment and interviewing for this study was a direct translation from English and described a set of women who engage in a certain behavior: *wanawake wanaobadilishana ngono kwa pesa*, women who exchange sex for money. Variations on this term, such as *wanaofanya biashara ya ngono* (those who do sex trade/exchange/business), were also used, and women were directly asked what they think about those terms and their difference, if any. In doing so, they often applied the terms to *other* women, but not themselves (despite having disclosed that they had exchanged sex for money within the past month).

*Baamedi*, from the English “bar maid,” was a label some women ascribed to themselves, but it also carried negative connotations, as *mabaamedi* (the plural) were assumed and even expected to be *malaya* (“whores”), whatever their actual behavior. The exceptional label was the phrase *dada poa*, which literally means “cool sister” or “cool young woman,” and seemed to be a positive or at least neutral term used by some sex workers themselves in certain towns as an alternative to the derogatory terms listed above. *Dada poa* referred specifically to woman who consciously used sex work to get

income, and actively sought clients, though they may or may not have asked for money explicitly. Only some women used this term, and some who knew it nevertheless did not apply it to themselves. Some women were uncomfortable with any label or description that referred to their sex work, reflecting the stigma in society against sex work.

## ***2.6 Contribution to Public Health***

This study contributes to public health in several ways. First, this study adds to research on the health of female sex workers. Even in places with generalized HIV epidemics, FSWs carry a disproportionate burden of HIV. According to a meta-analysis, FSWs in sub-Saharan Africa have 12.4 higher odds of having HIV/AIDS compared to other women in the general population (Baral et al., 2012). FSWs can also be at higher risk of STI, sexual and physical violence, alcohol abuse, and unwanted pregnancy (Harcourt & Donovan, 2005; Scorgie et al., 2012), particularly in criminalized work environments. Additionally, a significant proportion of HIV in the general female population is attributable to sex work; in sub-Saharan Africa, an estimated 98,000 deaths from HIV are due to sex work (Prüss-Ustün et al., 2013). Clearly, these populations require both programmatic and epidemiological attention to reduce their burden of disease, as well as transmission of HIV and STI to others.

Second, within research on sex work, very little is known about FSWs' reproductive lives and health. Other than a few key researchers who have written on pregnancy, contraception, and abortion (Decker et al., 2013; Todd et al., 2006, 2010), information on reproductive health among FSWs is secondary to other concerns, if discussed at all. In many settings, FSWs are stigmatized both in the wider community and

in healthcare services (Scorgie et al., 2013), and their particular healthcare needs may not be met through existing services that cater to the general population. Understanding FSWs' access to a variety of healthcare services in addition to HIV/AIDS and STI services is essential to adequately meet their needs to ensure their health and human rights.

Lastly, it has long been recognized that HIV-related risk behaviors are affected by people's broader environmental and structural circumstances (Sweat & Denison, 1995), but designing effective interventions that address these circumstances has been difficult. Although there have been successful structural interventions for sex workers in Asia and Latin America (Kerrigan, Fonner, Stromdahl, & Kennedy, 2013), interventions in sub-Saharan African have tended to focus on individual-level interventions such as condom use. As one sex worker activist in Dar es Salaam said to me, "Those NGOs—all they care about is condoms, HIV and condoms. We need more than that." In an effort to expand beyond the individual level, we approach FSWs as mothers, investigating how motherhood affects their working lives, and how it might impact HIV-related risks. As this is further understood, interventions such as those recommended in Chapter 8 can be designed to better address their multi-faceted needs.

## 2.7 Tables for Chapter 2

**Table 1. Reproductive Histories & Indicators among Female Sex Workers**

Country	Current Contraception	Lifetime Abortion	Ever Pregnant	Live Birth/ Child Rates	Sample Size*	1st Author	Year
Global							
Cambodia	1.6%	-	-	31.2%, living	632	Delvaux	2003
Uzbekistan	86.2%	60%	-	-	448	Todd	2006
Colombia	61%	-	-	85.4% 1+	514	Bautista	2008
Afghanistan	85.2%	26.8 to 54.9%	82.30%	51% 1+	428	Todd	2010
Thailand	5% <sup>a</sup>	5.40%	-	-	815	Decker	2011
India	83%	-	91.40%	78% 1+	326	Wayal	2011
India	-	-	-	90% 1+	850	Reed	2012
Russia	12% <sup>a</sup>	58.0%	69.7%	27.3%	147	Decker	2013
East Africa							
Kenya	-	-	-	82% <sup>b</sup>	385	Chege	2002
Kenya	-	86%	-	90% <sup>c</sup>	475	Elmore-Meegan	2004
Madagascar	-	-	26.7% <sup>d</sup>	-	935	Feldblum	2007
Madagascar	62%	45%	-	-	192	Khan	2009
Tanzania							
Northern	-	-	-	mean 3	106	Nkya	1991
Mbeya, Dar, Zanzibar	-	-	-	70% 1+	2820 bar workers	Akarro	2009
Arusha	-	-	-	mean 3	54	Renzaho	2009
Northwest	58.6% <sup>a</sup>	-	-	-	2719 bar workers	Watson-Jones	2009
Moshi	-	-	71%	-	1629 bar/hotel workers	Ao	2011

\*FSWs unless otherwise specified; <sup>a</sup> Hormonal; <sup>b</sup> Children at Home; <sup>c</sup> Dependent Children; <sup>d</sup> Incidence over 18-month follow-up

## **Chapter 3. Methods**

### ***3.1 Recruitment, Sampling, and Data Collection***

Between February and July, 2012, we conducted a study in the Iringa and Njombe regions of Tanzania to explore female sex workers' experiences with reproductive health and motherhood. This effort was a sub-study of a larger Strategic Assessment to Define a Comprehensive Response to HIV/AIDS in the area. A university-educated, female Tanzanian research assistant with previous research experience underwent a two-week training on qualitative research and research ethics before she obtained permissions from regional and local government leaders, and then followed recruitment and interview procedures as explained below.

There were three types of interviews: in-depth interviews (IDIs) with female sex workers; focus group discussions (FGDs) with FSWs; and key informant interviews (KIIs) with health care workers (HCWs), non-governmental organization (NGO) staff, and bar owners/managers. Each type is explained more below. See also Table 2.

All participants, regardless of type of interview, were compensated with 10,000 Tanzanian shillings (USD6) for their time and travel. This amount was commensurate with the larger strategic assessment study in which this study was based. All types of interviews were conducted in Swahili and audio-recorded with permission. Although some participants voluntarily used their given names in the interviews, no names were recorded in the transcripts to protect confidentiality. All names used in this dissertation are pseudonyms.

### **3.1.1 In-depth Interviews**

We developed an in-depth interview (IDI) guide with open-ended questions to direct questioning around certain topic areas, but encouraged the interviewer to probe extensively. Topics included daily life, work experiences, reproductive history, pregnancy and contraception, motherhood, childcare, paternity, intimate relationships, health issues including HIV prevention and treatment, and healthcare seeking. See the Interview Guides in Appendix 3. The target number of IDIs (n=30) was chosen *a priori* as more than adequate for saturation (Guest, Bunce, & Johnson, 2006).

The research assistant first approached owners/managers of entertainment venues, explained the purpose of the study, and requested approval to recruit women in the venues. She then approached women directly, informed them about the study, and asked them to participate. Additional women were contacted via snowball sampling through women who had already participated. The interviewer assured potential participants that (non)participation had no bearing on their employment, and that they were free to decline to participate or to stop the interview at any time.

A small number of participants became emotionally upset when relating difficult aspects of their personal histories, such as a violent husband or a death in the family. In these cases, the interviewer, who was also a trained counselor, expressed sympathy and stopped the audio recorder when she felt it was appropriate. This allowed the participants time to regain composure and decide whether or not to continue. One woman decided to stop the interview without completing the topics in the guide, but allowed the recorded portion to remain in the study. Other women asked for the interview to continue. After interviews were complete, the interviewer was ready to recommend follow-up services



such as counseling, as requested and as available.

Women were eligible if they were at least 18 years old, reported exchanging sex for money in the past month, and worked in entertainment venues (bars, clubs, etc.). Before each interview, the research assistant read an informed consent form aloud while the potential participant followed along, then carefully explained its meaning in plain Swahili. For women who could not read, the interviewer offered to have a third person known to the potential participant to read along in order to confirm the content of the consent form. She also allowed time for and answered any questions before obtaining oral consent. Oral consent was used rather than written consent to protect confidentiality. No women refused participation after the informed consent process. Interviews were conducted at a time and place convenient for the participants and that allowed for privacy, such as back rooms at bars, rented guesthouse rooms (paid for by the study), or participants' homes.

We purposively sampled the 30 women in the IDIs along demographic and phenomenal lines (Sandelowski 1995). Specifically, we sought women to represent a range of ages, locations, and venue types, as well as pregnancy experiences and numbers of children. We recruited women of different ages to gain a wide variety of experiences with life in general and in sex work, and more and less experience with reproduction and motherhood. We especially sought women with children, but we also sampled three with no currently living children in order to provide a wider range of experiences with reproduction and motherhood.

We recruited participants in different urban and semi-urban locations across

districts in two regions (Iringa and Njombe) in order to maximize any differences in types of work and clientele. For example, Ilula town had a large truck stop area; Mafinga town's venues catered to plantation workers; Makambako town contained a major crossroads; Iringa town was a regional seat of government; and Kilolo was a small district capital. There were multiple types of venues in the regions, including large "modern" bars that sold bottled beers and liquors (*baa*); smaller bars that sold bottled beers and liquors and perhaps locally-brewed alcohols (*grosari*); small, often informal "clubs" that sold mainly locally-brewed alcohols (*kilabu*, plural *vilabu*); as well as truck stops, guesthouses, and discos. The socioeconomic status of both the women that worked in these venues and the clients that visited them varied, so we made an effort to recruit at different types of venues. Thus, rather than a representation of all sex workers in the area, these women represent a range of experiences among sex workers.

### **3.1.2 Focus Group Discussions**

We used a specific guide for focus group discussions (FGDs); see Appendix 3. Topics in the FGDs included reproduction, motherhood, childcare, work experiences, health including HIV prevention and treatment, and healthcare seeking. Focus group discussions facilitate understanding of social issues, such as norms and expectations (Morgan 1997) and construction of local definitions of concepts of interest (Ivanoff & Hultberg, 2006), such as motherhood.

We conducted three FGDs with six, eight, and eight sex worker participants (a total of 22 women) in three different towns; the first FGD was comprised of women from both Iringa and Ilula, the second group was from Makambako, and the third from Ilula.

Women had the same eligibility criteria as for IDIs, and were recruited in the same manner as the IDIs, but more heavily through snowball sampling, e.g. referrals from women who had already participated. Some of the women in the FGDs had already participated in IDIs. In the case of Makambako, where an NGO had already been working with FSWs, a peer educator helped recruit the women. In each town, a suitable location was found that was private and comfortable for the FSWs, respectively, a back room at a bar, a conference room at a local guesthouse, and one participant's sitting room. Sex workers assisted in choosing the time and dates to minimize interference with work times.

The research assistant served as moderator, and a second research assistant was present to take notes and assist with audio recording. All women gave individual informed oral consent before participating. They were provided with snacks and drinks and compensated USD6 for their time and travel.

### **3.1.3 Key Informant Interviews**

The third type of interview was the key informant interview (KII). For the purposes of this study, we defined key informants as people who might have some expert knowledge on the research subject, but were not necessarily members of the target population itself, e.g. not sex workers. We recruited key informants from three different groups: healthcare workers (HCWs); staff of NGOs; and owners and managers of entertainment venues. We explain each type below.

The research assistant directly approached healthcare workers, explained the purpose of the study, and asked if they were willing to participate. In one location, the

preferred HCW was not available, so she recruited a different provider; otherwise, all agreed to participate. We purposively sampled HCWs from a variety of sizes and types of health care facilities. Thus, they came from various levels of both public and private facilities, including providers responsible for patient care at the regional hospital and two district hospitals; a district HIV/AIDS control coordinator (DACC); a municipal council HIV/AIDS control coordinator (CHACC); and a matron nurse of a private dispensary (a small health facility that provided basic services, such as testing and treatment for common diseases and conditions).

The research assistant directly approached staff members from NGOs, explained the purpose of the study, and asked them to participate. We purposively sampled to include NGOs that either targeted FSWs in their services or provided services that FSWs might have utilized (e.g. HIV/AIDS and/or reproductive services). All staff agreed, with the exception of one, who asked to postpone. This was because the NGO's work with FSWs had not yet started, and did not start until after the end of data collection. In total, three NGO staff members were interviewed. All NGOs provided some type of HIV/AIDS programming; we cannot provide more specific information about the NGOs' programming without compromising confidentiality.

The last type of key informant was bar owners and managers. We recruited them to provide a business-oriented perspective from people who had close interactions with FSWs. In some places, managers and owners of establishments where sex work takes place often have power over sex workers and may control salaries, give incentives or quotas for workers to have sex with bar patrons, take a percentage of sex workers'

earnings, etc. (Kerrigan et al., 2001; Scorgie et al., 2012); thus, we conducted these interviews to get a sense of power dynamics and relationships between owners/managers and workers. Participants in this category included a manager of a large, popular bar (*baa*) in Iringa town; a manager of a popular bar (*baa*) and guesthouse combination in Ilula; and two owners of local bars (*vilabu*), one in Iringa town and one in Ilula. Both of the *vilabu* owners were women and at least one of them had been a sex worker herself.

Interview guides for all KII were similar, with adaptations as relevant to their different type of workplace. See Appendix 3. Topics included the nature of the organization or business; any HIV/AIDS programming provided; populations served; general problems in the community; services provided for sex workers, if any; the nature of sex work in the area; and challenges faced in serving sex worker populations. We also asked HCWs various questions about reproductive health services provided for women in general and for sex workers in particular. We asked bar owners/managers about their clientele, the interactions between workers and management, and the challenges and risks FSWs faced.

### **3.2 Data Analysis**

Within 24 hours of each interview, the interviewer wrote a summary debrief of the interview, noting major topics and themes, as well as any issues related to data collection and recruitment. The interviewer and the lead author met at least weekly during the course of data collection to discuss findings, troubleshoot, adjust language in the guides, and monitor and guide variation in the sampling. These weekly meetings also allowed for an iterative research process of adjusting and adding questions as themes

emerged. For example, we made questions about reproductive history and contraception more in-depth and specific during the course of data collection.

All interviews were digitally audio-recorded and transcribed verbatim by the interviewer. A second transcriptionist transcribed some interviews; these were checked for accuracy by the interviewer. The author checked every transcription by listening to the audio recording while following along with the transcript. She also read all transcripts in Swahili multiple times, including while listening to the audio recordings, and added summary notes to the debriefing summaries. Additionally, the author created a matrix to facilitate quick comparisons across participants on key quantifiable characteristics including location, venue type, age, education, origin, reported HIV status, marital status, current intimate partnerships, condom use, contraceptive use, reproductive histories (number of pregnancies, abortions, miscarriages, live births), and information about children (number, ages, living situation, children's deaths, paternity). She then entered this data into Stata/SE (version 12.0, StataCorp, College Station, TX) and descriptively analyzed it for counts, frequencies, means, and medians, as relevant.

The lead author conducted thematic coding on the Swahili transcripts using Atlas.ti (version 7.0, Scientific Software Development GmbH, Eden Prairie, MN). First, she thematically coded sections on reproductive health and services, allowing salient themes to emerge from the data, then coded incident-by-incident, followed by axial coding to define categories, and memo writing to develop ideas (Charmaz 2006). Following this, she defined major reproductive health categories, including but not limited to intended pregnancy, experiences with ANC services, reasons for and

experiences with contraception, and experiences with family planning services, which we developed into Chapters 4 and 5.

Next, for Chapter 6, the author began the analysis with incident-by-incident coding to identify sections that concerned motherhood, childrearing, and information about children in general. Next, she conducted initial line-by-line coding on identified sections on five transcripts, followed by axial coding to define categories and sub-categories among these initial codes. From these categories, the author identified one—how motherhood and childrearing might affect sex work—for further development for the chapter. She then coded in detail all sections previously coded as relevant to motherhood on all transcripts, allowing themes to emerge from the data, which were further explored using Query and Families functions. Memos on key themes were also written to further develop ideas (Charmaz 2006; Friese 2012).

The lead author translated selections used as quotations in all chapters and the research assistant who conducted the interviews checked them for accuracy. We included and/or explained the original Swahili when we glossed the translation or when the Swahili words or concepts did not translate well into English.

### ***3.3 Ethical Considerations and Protection of Human Subjects***

We received ethical approval for this study from institutional review boards (IRBs) at Johns Hopkins Bloomberg School of Public Health (JHSPH) in the USA, and Muhimbili University of Health and Applied Sciences (MUHAS) and the National Institute for Medical Research (NIMR) in Tanzania.

### **3.3.1 Special Considerations in Sex Work Research**

Several researchers have brought attention to ethical issues that pertain especially to sex workers and other people who engage in activities that are illegal or stigmatized.

We paid attention to the following issues during the phases in the research process:

*Recruitment:* We made an effort to recruit from a variety of venues and socioeconomic statuses to be sure to hear from all kinds of FSWs (Wahab & Sloan, 2004). Gaining trust and building rapport required particular attention, as FSWs might be suspicious of motives, HIV tests, or undercover police (Shaver 2005). Indeed, police raided one venue for selling alcohol too early in the day while the research assistant was recruiting, and some FSWs required several contacts with the research assistant before being willing to talk to her. They were suspicious that their stories might appear in media outlets, and the research assistant reassured them of the strict confidentiality policies of the research. Thus, recruitment started slowly, but after a few FSWs were interviewed without negative repercussions, others were more willing.

*Data Collection:* It is important to realize that FSWs who participate in research have their own agencies, emotions, survival strategies, and motives for participating, and may purposely falsify information in order to save face or guard against stigma (Metzenrath 1998), which hails back to the importance of building trust. With a careful study of spoken (and unspoken) words and mannerisms, this can be seen as a rich source of data, rather than a source of bias. See especially Chapter 6.

*Data Dissemination:* It is especially important to note that researching FSWs can bring attention to them (and their children) and could do them harm if this information is used, for example, by police to enact counter-productive crusades against “immoral



behaviors” (Beard et al., 2010; Wahab & Sloan, 2004). Respecting confidentiality is extremely important to us in this study, so that individual women and specific venues cannot be targeted inappropriately. Since data collection, the Tanzanian MHSW has begun to draft policy on Key Populations (FSWs, men who have sex with men, and people who use drugs), especially on how to support these populations to reduce HIV/AIDS incidence among them and the general population. Thus, at least on the national level, Tanzania has the potential to use reports or publications in a positive way. I presented earlier versions of Chapters 4 to 6 at multiple conferences and meetings in Tanzania and they were well received.

### 3.4 Tables for Chapter 3

**Table 2. Research Participants by Type of Participant and Interview**

	In-Depth Interviews (IDI)	Focus Group Discussions (FGD)	Key Informant Interviews (KII)
Female Sex Workers (FSWs)			
Iringa	12	1 (n=12)	-
Ilula	9	1 (n=12)	-
Mafinga	3	0	-
Makambako	5	1 (n=8)	-
Kilolo	1	0	-
Total FSWs	30	22	-
Health Care Workers (HCWs)	-	-	6
Non-Governmental Organization (NGO) Staff	-	-	3
Bar Owners and Managers	-	-	4

## **Chapter 4.        “Do You Have a Husband?: Female Sex Workers’ Experiences with Intended Pregnancy and Antenatal Care Services in Southern Tanzania”**

### ***4.1 Abstract***

Understanding the pregnancy intentions and experiences of female sex workers (FSWs) is essential to tailoring services to adequately meet their needs. The aim of this study was to explore FSWs’ experiences with intended pregnancy and access to antenatal care and HIV testing within that setting in southern Tanzania. In-depth interviews and focus group discussions were conducted with FSWs, and semi-structured interviews with key informants. FSWs sought pregnancy to have families, avoid stigma, and/or solidify relationships. FSWs sought healthcare services, but rarely disclosed their occupations, complicating provision of appropriate care. Antenatal care services presented particular challenges; HCWs often required husbands’ presence to register and test women. Women adopted strategies to circumvent this barrier, including inventing husbands, revealing occupations as “barmaids,” and avoiding healthcare services until delivery. The discrimination FSWs faced as unmarried women in services is alarming, especially considering the HIV prevalence and incidence among FSWs in sub-Saharan Africa.

## **4.2 Introduction**

Female sex workers (FSWs) receive research and programmatic attention in sub-Saharan Africa due to their heightened risk for HIV and sexually transmitted infections (STI). Even in places with generalized epidemics, such as sub-Saharan Africa, FSWs carry a disproportionate burden of risk of HIV. A recent meta-analysis calculated an adjusted odds ratio of 12.4 compared to other women on the continent (Baral et al., 2012). The same behaviors that place FSWs at risk for HIV also place them at risk for unintended pregnancy. Increasingly, research is being conducted on contraception to prevent unwanted pregnancy, unmet need for contraception, and rates of induced abortions among sex workers (Decker et al., 2013; Todd et al., 2006, 2010). However, little is known about FSWs' pregnancy intentions, experiences with pregnancy, or their reception at antenatal care (ANC) services, and how they may have unique reproductive needs given their occupations.

In Tanzania, HIV prevalence is 5%, but the study sites, the Iringa and Njombe Regions of southern Tanzania, have the highest HIV prevalence in the country (9.1% and 14.8%, respectively) (Tanzania Commission for AIDS (TACAIDS) et al., 2013). It is unclear why these regions have higher rates, but it may be partly due to the numerous plantations in the region, which encourage seasonal migration of workers within the regions, and bring migrants from other regions as well. Additionally, the Tanzania-Zambia highway cuts through the regions, and entertainment venues such as guesthouses and bars line the highway to accommodate the truck drivers traveling to and from other parts of Tanzania, as well as Kenya, Malawi, Zambia, and the Democratic Republic of

the Congo.

The prevalence of HIV among FSWs in the two regions is unknown,<sup>1</sup> but other studies in Tanzania have found prevalence ranging from 19% among bar workers (Ao et al., 2006) to 60% among female truck stop workers (National AIDS Control Program 2005). HIV prevalence among FSWs in neighboring Mbeya Region, which is also along the Tanzania-Zambia highway, is as high as 68%, with a 9-month incidence of 13.9/100 person-years (Riedner et al., 2006).

While FSWs and other women of reproductive age share many aspects of pregnancy intentions and experiences, there are also unique dynamics among FSWs due to the context of their work. For example, many FSWs have sexual relationships with steady partners as well as both casual and regular clients, so there are multiple partnerships to consider (Murray et al., 2007) concerning pregnancy planning. Particularly concerning for FSWs are possible links between pregnancy and HIV acquisition (Gray et al., 2005), transmission (Mugo et al., 2011), and disease progression (Lieve et al., 2007). Both HIV-negative and HIV-positive FSWs can desire pregnancy, highlighting the urgency of enacting all four prongs of prevention of mother-to-child transmission (PMTCT) (UNICEF 2012), implementing new World Health Organization (WHO) and national guidelines for HIV treatment among pregnant women (World Health Organization, UNICEF, & UNAIDS, 2013), and ensuring equitable access to these services.

---

<sup>1</sup> There were recent efforts to estimate prevalence among FSWs in Iringa town, but data were unavailable at the time of writing (personal communication, PSI staff, November 2013).

FSWs are often stigmatized and face legal barriers (Ngugi et al., 2012; Scheibe et al., 2012; Scorgie et al., 2012), which can cause difficulties in accessing healthcare and receiving appropriate services. In a four-country study in Africa, sex workers reported significant barriers to health services including stigma and discrimination from healthcare providers (Scorgie et al., 2013). A recent report by Human Rights Watch recounted the barriers and discrimination both female and male sex workers experienced in Tanzania, including denial of care (Human Rights Watch & WASO, 2013).

Understanding the pregnancy intentions of FSWs and the contexts in which they seek pregnancy is essential to tailoring services to adequately meet their reproductive health needs, yet research on pregnancy among FSWs is rare. Studies reported that high proportions of FSWs experienced pregnancy (70%-90% in Tanzania, Russia, Afghanistan, and India) (Ao et al., 2011; Decker et al., 2013; Todd et al., 2010; Wayal et al., 2011) and had children (80-90% in Kenya) (Chege et al., 2002; Elmore-Meegan et al., 2004). An estimated two-thirds of all FSWs in sub-Saharan Africa have experienced pregnancy (Scorgie et al., 2012).

However, pregnancy intentions of these women are largely unexamined. A study in India found that over 18% of 326 FSWs were planning pregnancy, and of these, one-third were HIV-positive (Wayal et al., 2011). Likewise, a study in the Dominican Republic found that FSWs specifically sought pregnancy with certain clients (Kerrigan et al., 2003). Data from sub-Saharan Africa is especially sparse. Feldblum, et al, found that over 26% of FSWs in Madagascar had become pregnant in 18 months of follow-up during a condom intervention trial (Feldblum et al., 2007). However, none of these

studies explored the pregnancy intentions of FSWs qualitatively, particularly the contexts in which they seek pregnancy. The aim of this study was to qualitatively explore FSWs' experiences with intended pregnancy and access to ANC services in southern Tanzania.

### **4.3 Methods**

Between February and July 2012, a qualitative study was conducted to explore female sex workers' experiences with reproduction and motherhood. It was a sub-study of a larger strategic assessment to define a comprehensive response to HIV/AIDS in the area. A university-educated, female Tanzanian research assistant with previous qualitative research experience underwent a two-week training on qualitative research methods and research ethics before conducting recruitment and interviews. After gaining permission from regional and local government leaders, the research assistant approached owners/managers of entertainment venues, explained the purpose of the study, and requested approval to recruit women in the venues. Women were then approached directly, informed about the study, and asked to participate. Additional women were contacted through referrals from women who had already participated.

Women were eligible if they were at least 18 years old, reported exchanging sex for money in the past month, and worked in entertainment venues (bars, clubs, etc.). Before each interview, the researcher read and carefully explained an informed consent form and answered any questions before obtaining oral consent. Oral consent was used rather than written consent to protect confidentiality. Interviews were conducted at a time and place convenient for the participants and that allowed for privacy, such as back rooms at bars, rented guesthouse rooms, or participants' homes.

Purposive sampling along demographic and phenomenal lines (Sandelowski 1995) was used in order to achieve a variety of perspectives and experiences. Specifically, women were sampled across age, geographic location, and venue type. Women of different ages were recruited to represent a wide variety of experience with life in general and in sex work, and more and less experience with reproduction and motherhood. They were recruited in different urban and semi-urban locations across four districts in two regions (Iringa and Njombe) in order to maximize any differences in types of work and clientele. For example, Ilula town had a large truck stop area, Mafinga town's venues also catered to plantation workers, Makambako town contained a major highway crossroad, Iringa town was a regional seat of government, and Kilolo was a small district capital.

There were multiple types of venues in the regions, including large "modern" bars that sold bottled beers and liquors (*baa*); smaller bars that sold bottled beer and liquors and perhaps locally-brewed alcohols (*grosari*); small, often informal "clubs" that sold mainly locally-brewed alcohols (*kilabu*, plural *vilabu*); as well as truck stops, guesthouses, and discos. The socioeconomic status of both the women that work in and the clients that patronized these venues varied (Shagi et al., 2008), so an effort was made to recruit at different types of venues (Wahab & Sloan, 2004). Women were also recruited to represent a range of experiences with reproduction and motherhood, e.g. women with different numbers of pregnancies and children, and women with no pregnancies or children.

For interviews with FSWs, an in-depth interview (IDI) guide with open-ended



questions was developed to direct questioning around certain topic areas, but the interviewer was encouraged to probe extensively. Topics included daily life, work experiences, reproductive history, pregnancy and contraception, paternity, relationships, health issues including HIV prevention and care, and healthcare seeking. In total, 30 female sex workers participated in in-depth interviews. The target number of IDIs (n=30) was chosen *a priori* as more than adequate for saturation (Guest et al., 2006).

An additional guide was used for focus group discussions (FGDs). FGDs facilitate understanding of social issues, such as norms and expectations (Morgan 1997) and construction of local definitions of concepts of interest (Ivanoff & Hultberg, 2006), such as the importance and meaning of pregnancy. Three FGDs were conducted with six, eight, and eight participants in three different towns (Iringa, Ilula, and Makambako). Participants were recruited through venues; referrals from other FSWs; and in Makambako, referrals from a peer educator from a non-governmental organization (NGO) that worked with economically vulnerable women, including FSWs. Topics in the FGDs were similar to those in the IDIs.

In addition to FSWs, 13 key informants were also directly approached and recruited. They included staff from NGOs, healthcare workers (HCWs), government HIV/AIDS coordinators, and venue managers/owners. A guide was adapted slightly to type of informant, and included topics such as what services the institution provided in general, what services they provided for FSWs (if any), and challenges in the institution and in the community. For NGO staff and HCWs, there were also questions about how an FSW would be received in different circumstances, such as if she was pregnant, if she

had a sexually transmitted infection (STI), etc.

Interviews were conducted in Swahili, audio-recorded with permission, and transcribed verbatim. Identifying information was struck from the transcripts in order to protect confidentiality. Pseudonyms were assigned to each woman during analysis and are used in this paper. Within 24 hours of each interview, the interviewer wrote a summary debrief of the interview, noting major topics and themes. The interviewer and the lead author met at least weekly during the course of data collection, to discuss findings, troubleshoot, adjust language in the guides, and monitor variation in the sampling. This allowed for an iterative approach where questions could be changed or added over the course of data collection, as important themes emerged in interviews.

Thematic coding was conducted on the Swahili transcripts by the lead author using Atlas.ti (version 7.0, Scientific Software Development GmbH, Eden Prairie, MN). This analysis focused on reproduction and healthcare seeking issues. Sections on reproductive health issues and services were coded line-by-line, followed by axial coding to define categories, and memo writing to develop ideas (Charmaz 2006). For this manuscript, categories and codes related specifically to pregnancy intentions during sex work and experiences at ANC services were considered.

Additionally, as information was gleaned from the transcripts, a matrix was created to facilitate quick comparisons across participants on key quantifiable characteristics including location, venue type, age, education, reported HIV status, marital status, current and past intimate partnerships, reproductive histories (number of pregnancies, abortions, miscarriages, live births), and information about their children

(number, ages, paternity). This data was then entered into Stata/SE (version 12.0, StataCorp, College Station, TX) and descriptively analyzed for frequencies, means, and medians, as relevant.

Ethical approval for this study was received from institutional review boards at the Johns Hopkins Bloomberg School of Public Health, Muhimbili University of Health and Applied Sciences, and the Tanzania National Institute for Medical Research.

## **4.4 Results**

### **4.4.1 Participant Characteristics**

Women in IDIs (n=30) had mean age 28.9 years, with a range of 20-40 years. They worked in various venue types (21/30 from *baa* and *vilabu*), and seven sought clients in various sites, going from truck stops to *grosari* to *baa*, looking for the best crowd. The participants were spread across five towns and villages (Iringa town, Ilula, Kilolo, and Mafinga in Iringa Region, and Makambako in Njombe Region). None were currently married, and over half had never married, though about half had intimate partners. Three-quarters had primary school educations, and five had some secondary school education. See Table 3. Without being asked, three women disclosed they were HIV-positive.

They also had a range of reproductive histories. Women had experienced zero to six lifetime pregnancies, zero to five live births, and had zero to three living children, with a median of two on all of these. See Table 4. The 30 women reported 77 pregnancies in total, which resulted in 58 live births of 61 children (there were three sets of twins). All but one of the women had at least experienced pregnancy and childbirth. The one woman

who had never been pregnant was included as a negative case to bring in a different point of view, that of a sex worker who has no children, but nevertheless had views on pregnancy and sex work.

Women reported paternity of their pregnancies as well. Almost half of all the reported pregnancies occurred before initiation of sex work. About one-third of pregnancies (28/77 or 36.4%) were conceived with a husband, long-term cohabitating partner, or boyfriend who then became a husband/partner. Another five pregnancies (6.5%) were from casual, non-business sexual partners that did not then lead the couple to marry/cohabit, and two pregnancies were the result of rape. Just over half of pregnancies were conceived during sex work, both from casual clients (22/77, or 28.6%), and from regular clients (18/77, 23.4%). Many of the latter pregnancies were planned. The paternity of two pregnancies was not explained. See Table 5.

Key informants included staff from three NGOs; four HCWs (one doctor-in-charge and two medical officers-in-charge at district and regional levels, and one matron nurse at a private dispensary where FSWs reported seeking care); two government HIV/AIDS coordinators at district and town council levels; and four venue managers/owners (two from *vilabu*, one from a *baa*, and one from a *baa*/guesthouse combination).

#### **4.4.2 Experiences with Intended Pregnancy**

Although FSWs reported unintended pregnancies both before and during sex work, they also expressed pregnancy intentions and planned pregnancies, similar to most women of reproductive age. Of concern here is the unique contexts in which FSWs seek

pregnancy that may put them at risk for poor pregnancy outcomes and/or HIV and STI.

Women wanted to experience having children and families, and being called “Mama,” even if they did not have what some of them considered the “ideal” family situation of husband-wife-children. Thus, they sometimes made conscious decisions to seek pregnancy in unsafe circumstances. One woman, for example, had a daughter from a client, but wanted to try for a son. She did this by choosing a particular client to not use condoms with, but did not establish a relationship with him. She explained:

*My other one, the boy, truly I just decided myself... Oh, I just decided I wanted a boy, that's all. Yeah, I found a man. I had a child by him. During that time I continued with this [sex] work, using condoms [with the other clients] (IDI 525, Melissa, age 34, multiple sites, Ilula, 3 pregnancies, 2 children).*

Mlamka, a mother of 3, though not seeking pregnancy herself, explained how other FSWs sought pregnancy for a chance to have families:

*Some [FSWs] have just wanted to have children...she simply decides, “Hold on, now should I go to die like this without children?” Thus she is intending to get pregnant.... She simply decides, “Hold on, now I should have a child”...and there are some who can get pregnant by their clients, yes (IDI519, Mlamka, age 30, kilabu, Iringa, 4 pregnancies, 3 children).*

Estelle, mother of two, explained her desire to have children and to be called “Mama,” as she saw her peers doing:

*Yes, don't you just sit there, desiring? You are shocked that your peer has a child, and you desire that you have a pregnancy, and you go looking to become pregnant... You desire to bear [children], you desire that you have a child, that you be called Mama, that you have your family. You like that*

*[idea], so you seek pregnancy (IDI513, Estelle, age 24, kilabu, Iringa, 2 pregnancies, 2 children).*

Several woman referred to the status and respect women gain as mothers; “To be called Mama is respect,” one woman explained (IDI527, Sofia, age 26, baa, Ilula, 2 pregnancies, 0 children). Naiwa elaborated:

*When you are called Mama, it is great praise. To be called Mama is great praise. First, you are respected. Already you are called Mama So-and-So, you are respected to be called Mama So-and-So, you are respected to be called Mama So-and-So. To be called Mama So-and-So is high respect. And when you are called Mama So-and-So, you are confident, ‘I am a woman who is completed [mwanamke niliyekamilika].’ It is indeed praise to be called Mama (IDI508, Naiwa, age 28, baa, Mafinga, 3 pregnancies, 3 children).*

She played with Swahili language syntax here, using repetition and moving different phrases to the beginning of the sentence to show how emphatically she felt about the subject.

In contrast, infertility was highly stigmatized in Tanzania, and FSWs were not exempted from social pressure to bear children. One woman actively sought but had never experienced pregnancy despite using no form of birth control in her years as a sex worker; this made her “feel very bad” (IDI524, Patricia, age 26, baa, Ilula, 0 pregnancies). Another woman felt “simply great” about having born a child from a client, since she had avoided the stigma of being called childless:

*Is it not so that I won’t be called childless [mgumba]?...That it not be said, “This girl doesn’t reproduce, she’s a prostitute [malaya] but she*

*doesn't reproduce?!” That is something I should not like (IDI512, Shida, age 28, kilabu, Iringa, 5 pregnancies, 2 children).*

Regular clients also motivated FSWs to seek pregnancy, wanting to raise children with them or solidify their relationships. FSWs sometimes saw bearing clients' children as a route to relationships and financial security. They gambled that the father might go from client to long-term partner and breadwinner. FSWs had heard of this happening to others, as this woman related:

*Yes, they decide [to get pregnant with clients].... [It is] her agreement between her and her client, that “I want things to be thus and thus.” A small number of them agree. They bear [a child]. In the end they have their houses, and they stop this work (IDI527, Sofia, age 26, baa, Ilula, 2 pregnancies, 0 children).*

One woman did “settle down” [*kutulia*] to raise her child with a partner, but in this case it was only temporary.

*Really he was able to change me. He said, “Truly, I know you are a prostitute [malaya], but [life's] problems made you do this, so I want you to settle down.” So I bore a child, I settled down with him here in Iringa, and I had a good life, but...he passed away (IDI514, age 33, kilabu, Iringa, 2 pregnancies, 1 child).*

After he died from a sudden illness, she began to support herself and the child once again through sex work.

Others did not seek pregnancy as a way to leave sex work, but rather to gain or secure attention from a particular client. Chuki told her story about selective condom and contraceptive use to try to get pregnant with a certain man:

*I try very hard to use condoms, but for right now...for example, this man with whom I had a child when I was [working] at the bar. We spent a lot of time together at the beginning, and I was using the injections [Depo Provera] and condoms, but after he preferred that “Right now, me and you, we want to be together” and then we stopped using Salama [condoms]. We continued to have sex without, we went just so [hivi hivi, e.g., skin-to-skin]. Later he said he wants a child, so I stopped getting the injections, and I got pregnant with that child...He [the father] is a married man, but I just decided that I should have a child with him, because he cares about me to a certain degree, he helps my family...He cares about my family and he said he wants a family with me (IDI517, Chuki, age 38, kilabu & baa, Makambako, 3 pregnancies, 3 children).*

Such strategic childbearing did not always turn out so well for the women, however. Several women talked about men deceiving them into thinking they would be permanent partners and sources of income, only to deny paternity and leave them alone, pregnant. One woman explained:

*There are some [who intend pregnancy], yes, like if a person has deceived you [kudanganya]. One week, two weeks, he gives you money...Yes, you bear him a child.... He has deceived us. We have born children like this, and they don't care about us anymore (FGD545, Participant 1, Makambako).*

This was a difficult reality for women who were thus “deceived.” When asked about an experience in her life she would never forget, Sofia related:

*The day that I will always remember, and I will never forget in my life, is the day we planned, we discussed with each other that I should get pregnant, and then later he came to turn away from me. That's a shock*



*that affects me very much in my heart; I will not forget it (IDI527, Sofia, age 26, baa, Iringa, 2 pregnancies, 0 children).*

This intended childbearing with clients, followed by denial of paternity, happened not once, but twice to this woman. Both times she thought she had found a man she could settle down with, only to be hurt, and left with pregnancies she had to care for herself. In cases like these, many women consider or complete termination of the pregnancies, but sometimes, as for this woman, the pregnancy was already late term. Both times, she birthed and lost premature neonates. Not wanting to reach old age without a family to care for her, she attempted a third time to find a man to start a family with, but was rejected as “just a prostitute.”

Of the three women who disclosed they were HIV-positive, one, Mwajuma, expressed current fertility desires. Mwajuma was on anti-retroviral medications (ARVs) and had one child already, but desperately wanted a second. Before her diagnosis, she used to have unprotected sex with casual clients, hoping for another child. One of her regular clients, a married man who was also HIV-positive and on ARVs, visited her a couple times a month, and she did not use condoms or any birth control with him. Given that they were both HIV-positive and on ARVs, she did not see any problem with unprotected sex with him. She worried that she “had only one egg” and would never have another child, but nevertheless hoped (IDI520, Mwajuma, age 34, *kilabu*, Iringa, 1 pregnancy, 1 child).

#### 4.4.3 Experiences at ANC Services

There were no clinic-based services specifically for FSWs in the two regions. However, FSWs, like other women, reported seeking healthcare, including general outpatient care, treatment for sexually transmitted infections (STIs), family planning, ANC, PMTCT, and other HIV-related services. Women in this sample had experienced zero to six lifetime pregnancies; thus, most sought ANC services, which should include opt-out HIV testing according to national guidelines (Tanzania Ministry of Health and Social Welfare 2012).

In general, women reported that they were received and treated “like other women” at health centers. Sofia related:

*They [FSWs] are treated like regular people, because the hospital cannot know that I work in a particular business, they cannot know until you explain that “Yes, I do a certain business” (IDI527, Sofia, age 26, baa, Iringa, 2 pregnancies, 0 children).*

Likewise, HCWs and NGO staff reported that they treated FSWs “like any other women” whom they encountered. An NGO staff member explained:

*We give them all the services, like any other client who comes in wanting our services. Among which are getting them...first counseling and testing for HIV, getting them prevention services, and prophylaxis to protect the child (KII533, Iringa, NGO staff).*

However, FSWs reported a significant barrier to ANC services; they were refused services during pregnancy, including HIV testing, if they did not bring their husbands.

*These days, you cannot carry a pregnancy with the father not around, because if you are pregnant and go to the clinic, they do not test you [for HIV], they don't give you an [ANC] card, until they see the father, so they*

*can test you and they can test the father (FGD545, Participant 1, Makambako).*

Some women felt the need to deceive HCWs about their non-existent husbands, so they could get care.

*In the past...there was no asking about your husband and what not. You just gave your name and your husband's name, that's all. But nowadays, really, if you go to the clinic and there's no father, you are not allowed to test. Maybe you find another way, saying he is traveling and went far away. If you say he died, deceiving them, they tell you, "Go to your village leader and bring back a letter saying your husband died." Now, really, they do not test just anyone [ovyoyovy, carelessly] (IDI523, Johanna, age 28, kilabu, Makambako, 3 pregnancies, 2 children).*

Some women felt that such deception or inability to produce a husband subjected them to sub-standard care or none at all.

*If you do not open up to them, that "I do this particular work," you will not be received like she who came with her husband. Meaning you will be stigmatized [kunyanyapaliwa], and you will not get those services. Not until you deliver (FGD546, Participant 3, Ilula).*

One woman explained that this difficulty led some FSWs to avoid ANC services completely, delaying care seeking until they were in labor. According to her, this led to sub-standard care and stigmatization:

*Since these days the clinic does not receive you without your husband when you go to be issued an [ANC] card, you must go with your husband when you are issued a card.... Sometimes, you have to be open [wazi] at the hospital. If you are open, you are received. But if you hide [your occupation], you cannot be received... You will wait until...you are in*

*labor pains, and then you will be received. But even if you are received, you will not be served like if you had been issued a card at the beginning. That is, you will be stigmatized a certain amount, because you were not open from the beginning. But if you are open, you will receive all services (IDI527, Sofia, age 26, baa, Iringa, 2 pregnancies, 0 children).*

Thus, some FSWs found that they achieved the best care in the context of ANC services if they were open about being “barmaids” (*mabaamedi*, singular *baamedi*).

*A large percentage of us like to open up to the doctors and nurses, because there they ask you, “Do you have a husband?” If you say yes, well, they tell you that you should come with your husband so you can both get services. Thus, we open up completely, saying, if you are a barmaid, you say, “I am a barmaid,” and a lot of us use the term barmaid.... Because a large percentage of barmaids are seen to have no husbands at all, so they are always getting pregnant, and when we are received, we are tested and everything, and we continue on in care until delivery (FGD546, Participant 5, Ilula).*

Only FSWs in Ilula reported disclosing their occupations to HCWs. FSWs from other areas did not report this. On the other hand, even there, being open about being a “woman who exchanges sex for money” (*mwanamke anayebadilishana ngono kwa pesa*) as opposed to a “barmaid” (*baamedi*) reportedly got less desirable results. One woman explained why:

*It is the same except...they have a different understanding. I mean, straight away they direct you to the HIV [treatment clinic]... Over there they do not give you any services at all other than AIDS tests [vipimo vya UKIMWI, e.g. CD4 count] and starting medications [kuanza dozi]. They think straight away you are infected” (FGD546, Participant 5, Ilula).*

That is, in her experience, HCWs automatically assumed sex workers were HIV-positive, and referred them directly to care and treatment centers, rather than providing them with ANC or assessing if they need any other health services. Another woman from the same town likewise reported that sex workers at the ANC clinic are “separated” out from others. She used the word *kutenga*, translated as “to separate,” but connotes something stronger; it is commonly used to describe experiences that NGO workers called stigma and discrimination.

*Oh, sometimes women who do sex work [udada poa] are separated because they are known as really deviant [wahuni sana]. When it comes to the virus, it's easy for it to penetrate [kupenya] for them, yes (IDI530, Beatrice, age 31, multiple sites, Ilula, 2 pregnancies, 3 children).*

According to these women, even in the “friendlier” environment of this particular hospital, women were treated differently and discriminated against for being sex workers, which was immediately and exclusively associated with HIV. This was despite the fact they were pregnant and had obvious other healthcare needs beyond HIV testing and care, including PMTCT.

#### **4.5 Discussion**

As women of reproductive age, many FSWs want children and seek pregnancy, both inside and outside the context of their work environments. However, there are unique dynamics to consider due to their work environments, including the heightened risk of HIV and other STIs, which must be understood to tailor interventions to meet their needs. This paper highlights several critical aspects of FSWs’ social experience with

pregnancy and health services that are important to consider in the context of reproductive health and HIV prevention programming.

The female sex workers in this study had experienced between zero and six lifetime pregnancies, and zero and five live births, for a total of 77 reported pregnancies. Over half of all pregnancies reported by the 30 women in IDIs were conceived with clients, both casual and regular. Many of these pregnancies were intended.

Like other women of reproductive age, FSWs in this study expressed pregnancy desires and intentions, including the desire to have children and families, to expand an already existing family, and “to be called Mama.” For these women, to be called Mama was a sign of respectability and “complete womanhood,” a way to avoid the stigma of infertility, which was strong in Tanzania (Hollos & Larsen, 2008; Kielmann 1998). Haram described similar strategies among single, “modern” women in northern Tanzania of achieving respectability through childbearing (Haram 2003). Childbearing brought respectability to the women in this study, in direct opposition to the stigma they faced as sex workers and single mothers.

Other reasons for seeking pregnancy were focused on potential relationships with men. Pregnancy was seen as a way to secure long-term relationships or more financial security in a social and economic environment that disadvantaged women, especially single women. A life history approach to understanding FSWs’ lives in the Dominican Republic also found that FSWs sometimes sought pregnancy to secure relationships (Murray & MODEMU, 2002). This dynamic reflects an argument Guyer made about West African “polyandrous motherhood” (Guyer 1994). She argues that one “logic” of

reproduction is that children expand parents' social networks. That is, "particularly to women, children can be a means of creating new ties for oneself in a lateral strategy of network-building, giving opportunities for political and social mobility." Through their children, women can make claims to inheritance, property and social capital, even long after her sexual relationship with the father ends (Guyer 1994). The women in this study may have been engaging in this kind of dynamic where pregnancy was a strategy, and bearing children with multiple men (hence the term "polyandrous motherhood") could be advantageous to women, in that they could claim access to more social and physical capital. Women here found varying degrees of success with these strategies, as some clients denied paternity while others incorporated mother and child(ren) as family.

Thus, FSWs sought pregnancy for a variety of reasons. However, the contexts in which FSWs intended and sought pregnancy had potential impact on their HIV-related risk behaviors. For example, some women targeted paternity to particular regular clients with whom they were building long-term relationships. This likely increased risk to some degree, particularly since the men had other partners, and women rarely reported discussing HIV status with their partners and clients. Other women reported a potentially riskier strategy: seeking pregnancy by having unprotected sex with one or more casual clients, without discussing pregnancy intentions or HIV status with them. Understanding such dynamics can assist in program planning to improve both reproductive health and HIV services for FSWs. In particular, both HIV-positive and HIV-negative FSWs (and other women) may need assistance in identifying and implementing strategies for safe pregnancy planning that meet their fertility desires.

There were neither clinical services nor national guidelines for HCWs to meet the specific medical needs of FSWs at the time of this study. HCWs reported treating FSWs “just like any other women,” which was a desirable outcome in some ways, especially if this meant FSWs did not face stigma and discrimination at health services, as has been reported elsewhere (Human Rights Watch & WASO, 2013; Scorgie et al., 2013). However, this also meant that HCWs were unable to tailor services to FSWs’ circumstances, such as risk-reduction counseling, pre-conception counseling, ANC, PMTCT, and STI and violence screening.

Women reported only rarely disclosing their occupations with HCWs, which precluded such tailored care. This clinical silence was likely due to both societal stigma against sex workers and the legal status of sex exchange (Government of the United Republic of Tanzania 1981), but excluded a population at very high risk from the care they need. Even countries with generalized epidemics should focus on FSWs’ rights and access to health care, as an estimated 18% of HIV prevalence in the general female population is attributable to (unsafe) sex work in sub-Saharan Africa (Prüss-Ustün et al., 2013).

Women in this study reported barriers to ANC services, specifically because of presenting for services without accompanying husbands. According to participants, this requirement for a husband was new, though it is not clear where it originated. The Tanzanian Ministry of Health and Social Welfare (MHSW) guidelines encouraged but did not require an accompanying partner, and stipulated provider-initiated opt-out testing for all pregnant women (Tanzania Ministry of Health and Social Welfare 2012).



This focus on partners speaks to, and may be a result of, the international push for bringing men into care, particularly in the form of couples HIV testing and counseling (CHTC) services. The World Health Organization's guidelines on CHTC state that ANC services "present the most immediate and obvious opportunity for integration of CHTC" (World Health Organization 2012). There is sound reasoning behind this effort, such as including men in "discussions about sexual and reproductive health"; dealing with gender power inequities that make women unwilling or unable to consent to HIV-testing without husbands' approval; and reducing potential violence between couples (World Health Organization 2006, 2012). There is evidence for the health benefits of couples-oriented services (Aluisio et al., 2011), though evidence for effectiveness of male involvement in PMTCT programs specifically is scant (Auvinen, Kylma, & Suominen, 2013; Brusamento et al., 2012).

However, this study presents evidence of potential unintended negative consequences of well-intentioned ANC/CHTC policies. In practice if not in policy, services discriminated against FSWs, none of whom happened to have husbands in this sample. Without husbands, some women were denied enrollment into ANC services as well as HIV testing. As a response, women adopted strategies including inventing traveling husbands, revealing occupations as barmaids, or avoiding ANC services completely. The latter strategy has serious negative implications for the health of the pregnant woman and the fetus, including timely provision of PMTCT.

This same discrimination may apply to other single women, such as divorcees and widows, who are often economically and socially vulnerable, and have higher HIV

prevalence than other women in Tanzania (24.7% in widows and 15.2% in divorced/separated women versus 5.2% in married women) (Tanzania Commission for AIDS (TACAIDS) et al., 2013). Although the intent of HTC in ANC was not to deny testing to anyone, this exploration of FSWs' experiences through qualitative research uncovered this unfortunate and alarming occurrence in more than one district. Moving forward, guidelines should be clarified to address this issue and practitioners should be sensitized to the context-specific applications of when couples care is and is not appropriate.

This study was cross-sectional in nature, limiting the ability to follow women's reproductive health experiences over time. Another limitation of this study is that experiences in ANC care were self-reported by the women and HCWs, but no observations were made to ascertain actual practice. HCWs reported accepting and serving all healthcare clients, sex worker or not, but women reported some denial of services. Perhaps the women misunderstood HCWs' intentions around questions about the women's (non-existent) husbands, or perhaps HCWs reported expected behavior rather than actual behavior.

Furthermore, only one FSW in this study who disclosed her HIV-positive status expressed current fertility intentions, which limited understanding of potential comparisons between HIV-positive and HIV-negative FSWs. Further research is needed on pregnancy intentions and experiences, FSWs' access to all healthcare services, and FSWs' pregnancy-related outcomes, among both HIV-positive and HIV-negative FSWs.

Recent research reports on pregnancy *prevention* among FSWs, but FSWs also seek and desire pregnancy, sometimes in ways that increase HIV risk, and in turn, their reproductive health needs extend beyond contraception. Reproductive health interventions including but not limited to ANC and PMTCT must be tailored to fit FSWs' unique contexts. The health system could benefit from sensitization training for HCWs and national guidelines for healthcare services for FSWs. Community mobilization and empowerment interventions have shown promise (Kerrigan et al., 2013), and can reduce stigma and increase women's willingness and abilities to disclose occupations to HCWs and demand their rights in health care and beyond.

#### 4.6 Tables for Chapter 4

**Table 3. Demographic Characteristics of Female Sex Workers (n=30)**

Characteristic	Value/Type	n	%*
Age	20-24	8	26.7
	25-29	10	33.3
	30-34	7	23.3
	35-40	5	16.7
Venue Type	<i>Baa</i> (large bar)	7	23.3
	<i>Kilabu</i> (bar with local brew)	14	46.7
	<i>Grosari</i> (small bar)	1	3.3
	Truck Stop	1	3.3
	Multiple Sites	7	23.3
Town (District, Region)	Iringa (Iringa Urban, Iringa)	12	40.0
	Ilula (Kilolo, Iringa)	9	30.0
	Mafinga (Mafinga Urban, Iringa)	3	10.0
	Kilolo (Kilolo, Iringa)	1	3.3
	Makambako (Makambako, Njombe)	5	16.7
Education	None	2	6.7
	Primary School	23	76.7
	Some Secondary School	5	16.7
Marital Status	Never Married	17	56.7
	Divorced/Separated	10	33.3
	Widowed	3	10.0

\*Percentages may not sum to 100 due to rounding.

**Table 4. Reproductive Histories of Female Sex Workers (n=30)**

Characteristic	Value	n	%	Mean	Media
Lifetime Pregnancies	0	1	3.3	2.6	2
	1	4	13.3		
	2	12	40.0		
	3	7	23.3		
	4	3	10.0		
	5+	3	10.0		
Live Births	0	1	3.3	1.9	2
	1	10	33.3		
	2	12	40.0		
	3+	7	23.3		
Living Children	0	3	10.0	1.7	2
	1	9	30.0		
	2	12	40.0		
	3	6	20.0		

\*Percentages may not total 100 due to rounding.

**Table 5.        Reported Paternity of Pregnancies (n=77)**

<b>Timing</b>	<b>Relationship Type</b>	<b>n</b>	<b>%*</b>
Prior to Sex Work	Husband/Cohabiting Partner/Boyfriend	28	36.4
	Casual, Non-Sex Work Partner	5	6.5
	Non-Consensual Partner (Rape)	2	2.6
During Sex Work	Regular Client	18	23.4
	Casual Client	22	28.6
Unknown	Unknown	2	2.6

\*Percentages may not total 100 due to rounding.

## **Chapter 5. “A Qualitative Exploration of Female Sex Workers’ Experiences with Contraception in Southern Tanzania”**

### **5.1 Abstract**

**Objectives:** Female sex workers’ (FSWs) contraceptive needs are similar to other women of reproductive age, but they also present unique challenges, such as multiple types of partnerships and risk for sexually transmitted infections. However, little is known about their reasons for contraception use and their experiences with contraceptive services.

**Study Design:** In-depth interviews (n=30) and three focus group discussions (n=6, 8, and 8) were conducted with female sex workers in southern Tanzania. Interviews were conducted in Swahili, transcribed, and coded thematically using Atlas.ti.

**Results:** 18/30 women reported using modern hormonal and barrier methods. In addition to delaying, spacing, and ending childbearing, women expressed reasons for use related to financial instability, targeting paternity, distrust of condoms and men’s unwillingness to use them. FSWs’ mobility was a barrier to accessing services on time, but there were no obvious barriers within contraceptive services for FSWs. However, no woman in this study disclosed her sexual risks to providers. Peer outreach and education regarding contraception for FSWs inadequately addressed their lived realities as unmarried women with multiple partners.

**Conclusions:** Female sex workers’ contraceptive needs present unique challenges to consider in program planning and policy. Appropriate selection of methods accompanied by respectful counseling needs be tailored to FSWs’ needs, given their individual risks.

Sensitization training and guidelines on how to treat sex workers with respect and provide them quality services are needed.

## **5.2 Introduction**

Female sex workers (FSWs) in sub-Saharan Africa are at heightened risk for unintended pregnancy in addition to HIV (Baral et al., 2012). Increasingly, research is being conducted on contraception among FSWs (Decker et al., 2013; Todd et al., 2006, 2010), but little is known about their reasons for using contraception. FSWs' contraceptive needs overlap with other women of reproductive age, but they also present unique challenges. Relationships between hormonal contraception and HIV and STI are concerning, though incompletely understood (Delvaux & Buvé, 2013), and are likely to disproportionately affect FSWs. In Tanzania, FSWs' hormonal contraception use was significantly associated with HIV incidence (hazard ratio=1.6) (Watson-Jones et al., 2009). Also, FSWs have different types of sexual partnerships, so there are multiple dynamics to consider in pregnancy prevention (Yam, et al., 2013).

The study site, Iringa and Njombe Regions of southern Tanzania, have higher than average unmet need (26% vs. 18% nationally) (National Bureau of Statistics 2011), and the highest HIV prevalence (9.1% and 14.8%, respectively, vs. 5.1%) (Tanzania Commission for AIDS (TACAIDS) et al., 2013). While it is known that unmarried, sexually active women have higher contraception use rates than married women in Tanzania (45% vs. 27%) (National Bureau of Statistics 2011), little is known about contraception among FSWs. In a northwest Tanzania trial, 30% and 59% of FSWs were using a hormonal contraception at enrolment and follow-up, respectively (Watson-Jones



et al., 2009), compared to 16% in Madagascar (Feldblum et al., 2007) and over 80% in Asia (Todd et al., 2006, 2010; Wayal et al., 2011).

FSWs face significant barriers to healthcare services in sub-Saharan Africa, (Scorgie et al., 2013) including Tanzania (Human Rights Watch & WASO, 2013), but whether is it such barriers or other dynamics that drive their contraception use rates is unclear. This study aims to qualitatively explore FSWs' experiences with contraception use and services in southern Tanzania.

### **5.3 Methods**

February-July 2012, 30 in-depth interviews (IDIs) and three focus group discussions (FGDs) (participants=6, 8, and 8) were conducted with FSWs. The number of IDIs was chosen *a priori* as adequate for saturation (Guest et al., 2006). FSWs were eligible if they were at least 18 years old, reported exchanging sex for money within the past month, and worked in entertainment venues. Purposive sampling for demographic and phenomenal variation (Sandelowski 1995) was used to recruit women across age, location, and venue type, and with varied histories of pregnancy and childbearing. All participants gave oral informed consent and were compensated USD6.

An interview guide covered certain topic areas (reproduction, healthcare seeking), but the interviewer probed extensively. Interviews were conducted in Swahili by a trained, bilingual Tanzanian, and transcribed verbatim. Swahili transcripts were coded using Atlas.ti (version 7.0). Sections on reproductive health and services were coded, allowing themes to emerge from the data (Charmaz 2006). Quotations were translated by the author and checked for accuracy by the interviewer.

Ethical approval for this study was received from institutional review boards at Johns Hopkins Bloomberg School of Public Health, Muhimbili University of Health and Applied Sciences, and the Tanzania National Institute for Medical Research.

## **5.4 Results**

Women in IDIs (n=30) had mean age 28.9 years. They worked in venues in five towns in two regions. None were currently married, and half had intimate partners. Three-quarters had primary school educations (Table 6). Three women disclosed they were HIV-positive. Median was two for lifetime pregnancies and live births. They reported 15 induced abortions. Over half (18/30) reported using modern hormonal and barrier methods (condoms). See **Figure 1**. Almost all women (27/30) reported (inconsistently) using condoms for disease prevention. Others used rhythm methods with or without condoms; one used no method because she sought pregnancy. Some did not discuss which contraceptive method they used (Table 7).

### **5.4.1 Reasons for Contraceptive Use**

Like other women of reproductive age, FSWs had reasons for contraceptive use related to delaying, spacing, or ending childbearing. For example, one woman used injections because she felt she was old enough to stop childbearing, even if a man wanted her to continue:

*If a man says I should bear a child, truly now, I would refuse him...For me, the time for reproduction, the age of bearing children is over. That is why I say, for me, right now, I love my family, I should take care of my family (Makambako, age 39).*

For women not in stable, long-term relationships, there were considerations such as financial instability.

*I get the injections [because] maybe, I am afraid I will become pregnant, and then it will be unplanned....How would I raise that child when my own life is so hard? I do not know how I will raise the one I have, and if I have another, how would I raise her? That's the main reason I like to protect myself with injections (Ilula, age 22).*

Women also sought to target paternity. One woman selectively used condoms as pregnancy prevention with one regular partner but not with another so that all her children would have the same father:

*The one I do not use condoms with is the one I bore children with already...But the partner I have right now, no, [we use] condoms as usual because [laughs] he is a married man...I do not want to bear children who each have their own father...I want three children, but I will try hard to have [the third] with the father of the other two (Iringa, age 24).*

Another reason for contraceptive use was a distrust of condoms,<sup>2</sup> which was generated for a couple of reasons. First, clients could not be trusted to use condoms.

---

<sup>2</sup> Male condoms were available cheaply or for free at various pharmacies, health facilities, retail shops, and entertainment venues (though inconsistently). Commercial brands (e.g. Trojan) as well as socially marketed, subsidized brands were available to target a variety of customer bases (e.g. *Dume* for richer men, *Familia* for family planning, *Salama Studs* for high-risk populations). *Dume* and *Salama* were especially promoted in *baa* (large modern bars) by NGOs. Two subsidized brands of female condoms were promoted at intervention events for FSWs, but were uncommonly available in shops and pharmacies. Though condom use was not the focus of interviews, women shared aspects of condom use and negotiation that should be noted for future research and interventions.

Awareness of condoms was high. Twenty-seven of the 30 women in IDIs at least mentioned condoms, 16 of them without prompting. Knowledge did not necessarily mean practice, however. Some women, such as ones who were explicit about their sex work, reported being proactive about condom use with clients. Others willingly agreed to forgo the condom if the client offered more money (usually double the price). Still others left all decisions about condoms to the clients, with no discussion on condoms, birth control, or HIV and STI. One woman said she told her clients that she was HIV-positive but some men still refused to use condoms with her.

Women said men paid more for sex without condoms, or clients forced unprotected sex with women.

*Some people use condoms, but in sex work, you cannot say you use condoms as birth control because how the condoms are used. When a man arrives and pays a different price for [sex] with condoms, won't you have to forget the condom? (Ilula, age 34).*

Second, multiple women feared and had experiences with condom breakage, which could result in pregnancy.

*[Condom breakage] has happened to me, and that's why I fear it could happen like that, and then I will become pregnant, and then how will it be*

---

Even when women did want to use condoms, the clients held the power over condom use. Many women reported that men made threats or became violent when the women asked about using condoms, and many women reported being physically beaten by clients over a suggestion of condom use. Thus, some women were afraid to raise the issue, and left it to the men to decide. This was a reason that interventions for FSWs also promoted female condoms, as a way to bring the control to the women. These intervention sessions also taught women other strategies, such as keeping the light on in the room so they can do visual inspections of clients' genitals before sex.

There was also a difference in condom use between types of clients. FSWs expressed an idea that men they knew were safer and could be trusted, so they were less likely to feel the need for condoms with them. For example, travelers and truckers were less likely to be trusted, and women tried harder to use condoms with them compared to men from the neighborhood or men they had seen several times already at the bar. FSWs might be more likely to want to use a condom the first time with clients, but condom use was reported to stop very shortly thereafter, such as after a couple encounters. FSWs, then, were less likely to use condoms with regular clients, since they knew them (though never having discussed HIV status, and knowing the men had other partners as well). Clients could change the relationship to something more regular by giving money or gifts that were not in direct one-to-one exchange for sex, in particular if there was an emotional attachment or a desire for children.

Although there were several popular rumors around Tanzania about condoms (they had been purposely infected with HIV; they did not prevent pregnancy; they caused reproductive harm; they got stuck in the woman; they did not work), participants in this study did not express these ideas. Rather, they seemed to generally trust that condoms prevented pregnancy, STI and HIV; their concerns were with men's (un)willingness to use them and possible breakage. It is unknown how often breakage occurred; it is possible that women shared the stories about breakage because it was surprising and alarming, but not necessarily common. As the condoms available locally were of good quality, it is not clear why breakage might have occurred. Perhaps it was user error; they were using expired condoms, were opening and/or putting them on incorrectly, were using two at once, were using oil-based lubricant, or were re-using condoms. All of these behaviors were discussed as inappropriate in condom demonstrations for FSWs. In demonstrations, FSWs were also told to dispose of condoms by tying a knot in them and dropping them in a pit latrine. However, women in this study did not discuss disposal, so it is unknown what disposal practices they used. With the proliferation of flush toilets it seems unlikely that all condoms were thrown into pit latrines, especially in towns.

*for me?...I went to sleep with a man, he put on a condom. I saw it. But when it came time, I found the condom had broken at the end...That's why I am very scared (Ilula, age 22).*

Not all women distrusted condoms, however. One woman disliked the side effects of other methods, so now used condoms for contraception. "Right now I watch the calendar, because I do not do it without condoms. Without condoms right now, I cannot do anything at all" (Iringa, age 20).

#### **5.4.2 Experiences with Contraceptive Services**

Contraceptive services were available for free to all women in Tanzania via public and private clinics, and in one district, an NGO also provided contraceptive education to FSWs through peer outreach.

FSWs' mobility made access difficult. FSWs spontaneously traveled with truckers for days or weeks, and this created difficulty in accessing services or refills on time. While some planned ahead and brought enough pills with them, others felt they could not leave their clients, nor attend an unknown clinic.

*If she gets a client, maybe they travel....The date of her appointment arrives when she was told to return there to go get her injection, or to get her pills, you see? Or to put in another implant, to change that one because the time for that medicine to do its thing has expired. So it's hard and you don't have the smarts to run away from that client, because you are with him shoulder-to-shoulder. Now in that state you continue to have sex. Some refuse to use condoms...and then...your medicine time has run out, and you haven't gone [to the clinic]. So...your time to bleed arrives and you see it is silent, you watch for the following month, you see it is*

*silent. If you run to the hospital, you are told you are pregnant (Ilula, FGD Participant 5).*

Once at services, women who used modern methods did not report barriers related to being FSWs, although none reported disclosing their occupations to healthcare workers (HCWs) while seeking contraception. When asked if the providers knew the women's occupations, for example, one participant replied,

*Themselves, they know matters of pregnancy planning. They just give injections there. Because they do not ask you anything at all. They just ask you, 'Which method do you use?' and that is all (Iringa, age 30).*

Participants recognized that they would not be known as FSWs unless they disclosed this information themselves, which they rarely did. Women wanted to and were able to appear like “regular women.”

*They will be treated like other women who go to the hospital...Because when they go to the hospital, how will it be known that they do sex work?...Will it not be like other women? (FGD544, Iringa/Ilula, Participant 2).*

Others received injectable contraceptives at pharmacies to maintain secrecy and avoid long, public lines at clinics. Contraceptive pills were also available legally and cheaply at pharmacies, though no women reported accessing them there.

Five of the women worked in an area with peer-based outreach services that integrated contraceptive education into an HIV-prevention package for FSWs. Women related their positive experiences with this service, saying that more FSWs were using contraception now. A peer educator related:

*We have learned about unintended pregnancies...if you are bearing one after the other, the mama gets worn out...And really people have learned. They have gone to get implants, they have gone to get injections, each one the method she likes (Makambako, age 39).*

However, the education materials appeared to be targeted toward monogamous, married women, despite integration into an FSW intervention. The education materials assumed a husband:

*But the way we were told [in training], we taught them [FSWs]...You will be increasing the amount of time the father goes to sleep with other women [due to pregnancy and/or breastfeeding abstinence periods]...Yes, you two have arranged your pregnancy planning, the father and the mother, [saying] “Let’s bear children, bwana, we have a child, now let’s plan our childbearing. What shall we use, what shall I use, my companion, shall I use implants or shall I use an IUD, or shall I use such-and-such?” You consult with one another, “Right now, to have a child, bwana, is not good” (Makambako, age 39).*

She—a widow—continued, explaining how a wife could motivate her husband to limit childbearing and convince him to use contraception for the benefit of “their” family.

## **5.5 Discussion**

The results here explored how FSWs use contraception and access services, and how their service needs presented unique challenges. As seen here, FSWs wanted and used modern forms of contraception. The methods reported by these women match the types most used in Tanzania; injectables, condoms, pills, and implants were most common, and intrauterine devices (IUDs) and female sterilization were available but uncommonly used (National Bureau of Statistics 2011). Other barrier methods such as

diaphragms were unavailable, though nurses had demonstration samples in clinics. Female condoms were also available, and though a couple FSWs reported using them, none reported using them for contraception.

Some women did not mention any contraceptive method whatsoever. Whether this was due to a lack of awareness, non-use, or simply due to not being directly asked during interview probes is unclear. It is telling that although the discussion turned on reproductive health, pregnancy, and childbearing among FSWs, almost one-third of women did not raise the topic of contraception at all.

FSWs have reasons for contraceptive use that are similar to other women of reproductive age, such as delaying, spacing, and ending childbearing. Women in this study also expressed reasons related to financial instability, targeting paternity given multiple partnerships, and distrust of condoms and men's (un)willingness to use them. The authors know of no other study that has explored FSWs' reasons for contraceptive use to date, though two studies mention reasons for non-use or non-need, such as being pregnant or menopausal (Todd et al., 2010; Wayal et al., 2011).

An additional key issue for FSWs' contraception is the fact that many also want to bear children for a variety of reasons, including desires to have families, avoid stigma against infertility, and solidify relationships with men (see Chapter 4). Furthermore, FSWs have sexual relationships with steady partners as well as clients. Thus, long-term methods may be inappropriate for women who want to prevent pregnancy with certain men but not others. Unfortunately, other than female condoms, female-controlled barrier methods that FSWs could use selectively were unavailable.



Women reported one significant barrier to services related to their work as FSWs. They often accompanied truckers on trips, and this interfered with their ability to access services on time. Once at services, however, there were no obvious barriers to contraception. This is positive, in that they were not denied access, stigmatized, or discriminated against, as they have been in other healthcare settings (Human Rights Watch & WASO, 2013; Scorgie et al., 2013). However, no woman in this study disclosed her occupational or sexual risks to providers when seeking contraception. Disclosure to respectful, well-trained providers could assist women in finding the right (dual) methods for them given their condom (non)use, number of partners, risk and history of STIs, HIV status, and pregnancy intentions. For example, IUDs are inappropriate for women at very high risk for STI (World Health Organization 2010) and hormonal methods may increase HIV and STI risk (Delvaux & Buvé, 2013), but healthcare providers may prescribe these to FSWs, unaware of their risks. Furthermore, contraceptive education provided to FSWs inadequately addressed their lived realities as (usually) unmarried women with multiple partners. Indeed, FSWs here were free to choose their contraceptive methods and timing, without regard to a husband.

This study is limited in its cross-sectional nature. Thus, women's reports of contraceptive use were retrospective, and details such as which type of injectable they used and for how long were not given. Also, contraception was but one of many topics within interviews; further research is needed to more fully understand the nuances of use, non-use, and discontinuation, as well as the proportions of FSWs who use particular methods, their correlates and predictors.

FSWs' contraceptive needs overlap with other women of reproductive age, but they also present some unique challenges to consider in program planning and policy. Selection and prescription of methods needs be tailored to FSWs' needs and individual risks. This should be accompanied by appropriate, respectful counseling to help them choose the best methods for them. To achieve this, healthcare workers could benefit from sensitization training as well as national guidelines on how to treat FSWs with respect and provide them with quality services. A wider variety of modern methods could be made available to FSWs through outreach or other appropriate programs. Finally, community mobilization and empowerment interventions can help women by reducing societal stigma as well as self-stigmatization (Kerrigan et al., 2013), encouraging them to speak freely with providers about their risks and needs, and to monitor and provide feedback on the quality of services provided to them as a community.

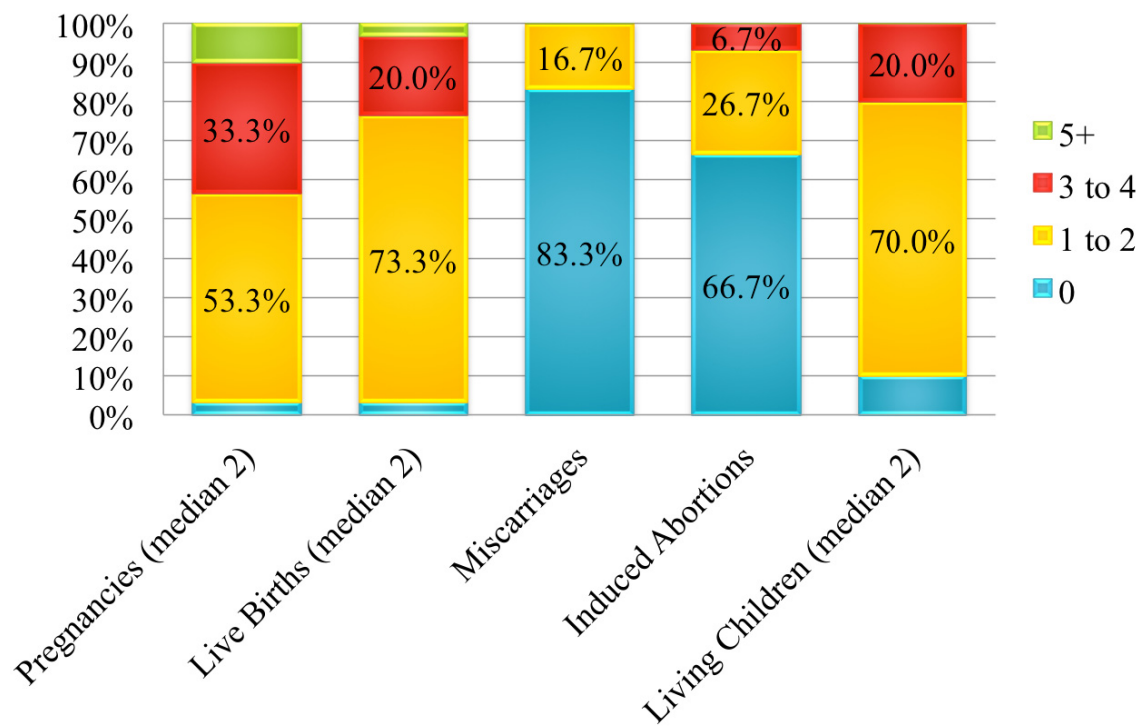
## 5.6 Tables & Figures for Chapter 5

**Table 6. Demographic Characteristics of Female Sex Workers (n=30)**

Characteristic	Value/Type	n	%*
Age (mean=28.9)	20-24	8	26.7
	25-29	10	33.3
	30-34	7	23.3
	35-40	5	16.7
Venue Type	<i>Baa</i> (large bar)	7	23.3
	<i>Kilabu</i> (bar with local brew)	14	46.7
	<i>Grosari</i> (small bar)	1	3.3
	Truck Stop	1	3.3
	Multiple Sites	7	23.3
Town (District, Region)	Iringa (Iringa Urban, Iringa)	12	40.0
	Ilula (Kilolo, Iringa)	9	30.0
	Mafinga (Mafinga Urban, Iringa)	3	10.0
	Kilolo (Kilolo, Iringa)	1	3.3
	Makambako (Makambako, Njombe)	5	16.7
Education	None	2	6.7
	Primary School	23	76.7
	Some Secondary School	5	16.7
Marital Status	Never Married	17	56.7
	Divorced/Separated	10	33.3
	Widowed	3	10.0

\*Percentages may not sum to 100 due to rounding.

**Figure 1**      *Reproductive Histories of Female Sex Workers (n=30)*



**Table 7. Current Contraception Use of Female Sex Workers (n=30)**

Category	Type	n	%
Hormonal Contraception	Injections	10	33.3
	Implants	4	13.3
	Oral Contraceptive Pills	2	6.7
	Unspecified Modern Method	1	3.3
Non-Hormonal Contraception	Condoms for Contraception	1	3.3
	Rhythm/Calendar	2	6.7
	None	1	3.3

\*Percentages may not sum to 100 due to rounding.

## **Chapter 6.       *“If You Have Children, You Have Responsibilities: Motherhood, Sex Work, and HIV in Southern Tanzania”***

### ***6.1 Abstract***

**Background:** Many female sex workers begin sex work as mothers, or because they are mothers, and others specifically seek childbearing. Motherhood may influence women’s experiences and livelihoods as sex workers and subsequent HIV risks. We employ Connell’s Theory of Gender and Power to explore the intersections between motherhood, sex work, and HIV-related risk.

**Methods:** We conducted a qualitative study with female sex workers in southern Tanzania, including 30 in-depth interviews and three focus group discussions. Women were eligible if they were at least 18 years of age, reported exchanging sex for money in the past month, and worked in entertainment venues. We purposively sampled women to represent a spectrum of experiences with motherhood, e.g. women with children at home and away, and women with different numbers of children. Interviews were conducted in Swahili, audio recorded, transcribed verbatim, and coded thematically using Atlas.ti.

**Results:** Women had an average of two children, and two-thirds of them had children living with them. Women situated their socially stigmatized work within their respectable identities as mothers doing whatever was necessary to care for their children. Being mothers affected sex workers’ negotiating power in complex manners, which led to both reported increases in HIV-related risk behaviors (accepting more clients, accepting more money for no condom, anal sex), and decreases in risk for the sake of the children

(protecting one's long-term health by using condoms, refusing sex without condoms, testing for HIV).

**Discussion:** Sex workers who were mothers were aware of risks they could encounter in their jobs, but with children to support, their choices were constrained. They explicitly connected their decision-making and HIV-related behaviors to their children's welfare and to their roles as mothers. Mothers have financial and practical needs such as school fees and childcare, which should be considered in future policies and programming.

## **6.2 Introduction**

Iringa and Njombe Regions of southern Tanzania had the highest HIV prevalence in the country at 9% and 14%, respectively, versus 7% in Dar es Salaam, the largest city, and 5% nationally (Tanzania Commission for AIDS (TACAIDS) et al., 2013). In sub-Saharan Africa female sex workers (FSWs) had 12.4 times higher odds of having HIV than other women in the general population (Baral et al., 2012). The prevalence of HIV among FSWs in Dar es Salaam was 30% (National AIDS Control Programme 2012). Other studies in Tanzania found prevalence ranging from 19% among bar workers (Ao et al., 2006), to 60% among women at truck stops (National AIDS Control Program 2005), and 68% in neighboring Mbeya Region (Riedner et al., 2006).

As most FSWs are women of reproductive age, many have children. It is estimated that over two-thirds of FSWs in sub-Saharan Africa have children (Scorgie et al., 2012). Two studies in northern Tanzania found FSWs had three children on average (Nkya et al., 1991; Renzaho & Pallotta-Chiarolli, 2009), and another study reported 70% of bar workers had at least one child (Akarro 2009). In two studies in Kenya, 82% and 90% of FSWs had dependent children (Chege et al., 2002; Elmore-Meegan et al., 2004). Elsewhere, the percent of FSWs reporting at least one child ranged widely: 27% in Russia (Decker et al., 2013), 51% in Afghanistan (Todd et al., 2010), 85% in Colombia (Bautista et al., 2008) and 90% in India (Reed et al., 2012).

Thus, motherhood and sex work overlap. A few studies have suggested that financially supporting children was a major incentive for women to participate in sex work, where they may be able to make more money than in other jobs available to them



(Kerrigan et al., 2001; Murray & MODEMU, 2002; Scorgie et al., 2012). Others showed that sex workers sometimes specifically sought childbearing (Kerrigan et al., 2003; Wayal et al., 2011), perhaps as a way to leave sex work by securing the father's financial and/or emotional attention (Haram 2003; Murray & MODEMU, 2002). Classic writings on sex work mentioned the existence of sex workers' children, but rarely discussed how motherhood and sex work intersected (Delacoste & Alexander, 1987; Pheterson 1989).

Despite these intersections of motherhood and sex work, HIV prevention efforts have seldom addressed these complex realities, and gaps remain in the literature about how motherhood can affect sex work, especially for sub-Saharan Africa. To more deeply explore these issues, we employ Connell's Theory of Gender and Power to understand the intersections between motherhood, sex work and HIV-related risk behaviors among female sex workers in southern Tanzania.

### **6.2.1 Motherhood, Sex Work, Gender and Power**

Connell's Theory of Gender and Power (TGP) (Connell 2002, 1987) provides a framework for analyzing gender relations, and names four structures of gender—labor, power, emotional, and symbolic relations—which intertwine to ideologically shape “women” and “men,” “masculinity” and “femininity” (Connell 2002; Maharaj 1995). These structures place constraints on members of society, but are (re)constituted through practice (Connell 1987), and are thus “vulnerable to major changes,” (Maharaj 1995). That is, people have agency to act within their structures, to resist and change them. The TGP can be used to analyze various institutional and socio-historical contexts (Maharaj 1995), such as motherhood and sex work in post-colonial Tanzania, which would be

heavily influenced by, but nevertheless structured differently than, motherhood among other women in Tanzania.

The gendered structure of labor can be seen in motherhood. Scholarship on motherhood often focuses on activities of mothers, what mothers *do*, such as performing childcare tasks (Arendell 2000). In Tanzania, mothers (and women) fulfill most of the childcare and household responsibilities, while fathers are expected to provide financial support (Kiaga 2007). In the hospitality and entertainment industries where many FSWs operate, employees are selected for particular tasks more “suitable” to their gender (Fischer 2013a, 2013b). Gendered labor structures also apply to sex work. Firstly, sex work is work (Delacoste & Alexander, 1987), and the labor structures of sex work, particularly its widespread criminalization, lead to occupational health and safety issues (Alexander 1998), including increased risk for HIV (Ahmed, Kaplan, Symington, & Kismodi, 2011). The lack of economically viable employment opportunities for women that so often leads to or perpetuates poverty is implicated as one reason women enter sex work in sub-Saharan Africa (Scorgie et al., 2012). Furthermore, it is often men who manage, regulate, and police sex work (Delacoste & Alexander, 1987; Harcourt & Donovan, 2005). Even in cases where women work independently, as in sub-Saharan Africa (Scorgie et al., 2012), the gendered division of labor remains: it is mostly men who buy and women who sell sex.

The gendered divisions of power (structures of “authority, control, and coercion”) (Connell 1987) manifest in women’s low control over household decisions in Tanzania (National Bureau of Statistics 2011). Laws and policies also favor men/fathers in

inheritance, divorce, and custody (Kiaga 2007). In contrast, African feminism, although acknowledging the oppression of women and the control of the institution of motherhood by men, presents a “motherism” where motherhood is empowering, powerful, and privileged (Akujobi 2011; Walker 1995). The gendered division of power affects sex work, as seen in numerous studies that show women’s inequality, vulnerability to disease and violence, inability to negotiate condom use, etc. (Hampanda 2013; Renzaho & Pallotta-Chiarolli, 2009; Scorgie et al., 2012). This gendered power is epitomized in the “gold standard” of HIV prevention: the condom, a male-controlled method (Alexander, Coleman, Deatruck, & Jemmott, 2012). Although men often wield power in paid sexual encounters, much HIV prevention work around sex work has been to encourage condom use among women, not their clients (Barrington et al., 2009).

The gendered structure of emotional relations encompasses affect, family, gender roles, and attachments (Connell 2002), and “describes how women’s sexuality is attached to other social concerns” including ideas about “impurity and immorality” (Wingood et al., 2000). Women in Tanzania are expected to marry and be dependent on and obedient to their husbands (Kiaga 2007). Motherhood is essential to women’s respectability (Haram 2003), adulthood (O’Malley 2002), and womanhood (Haws 2009). Tanzanian women are imagined to be asexual before marriage, and monogamous within it, though they are often not (Nnko, Boerma, Urassa, Mwaluko, & Zaba, 2004; Wamoyi, Wight, Plummer, Mshana, & Ross, 2010). Expectations about women’s sexuality certainly are attached to debates over sex work (Nagle 2010) and contribute to stigma (Maduna-Butshe 1997; Scambler & Paoli, 2008) and violence against sex workers (Scorgie et al., 2012).

Symbolic relations refer to meanings—the socially constructed interpretations of the gendered world. There are a host of meanings attached to motherhood and to sex work. Just as one becomes a woman not by being born anatomically female, but by performing societally expected femininities (Connell 2002), one becomes a mother not by giving birth, but by practicing motherhood. Thus, motherhood is far more than biological reproduction of children; it is a concept, an institution (Akujobi 2011), and a social identity (Walker 1995). As a “facet of culture” rather than a “fact of nature” (Sudarkasa 2004), the meanings given to motherhood in African societies are different than elsewhere. For example, Akujobi posits an “African motherhood” in which mothers are “respected and mythologized” (Akujobi 2011). This contrasts with sex workers, who are stigmatized and blamed for HIV; they symbolize HIV risk.

When women are both mothers and sex workers, the gendered structures become increasingly complex and even contradictory. A handful of scholars have explored this. Castañeda, et al, argued that sex worker mothers in Mexico faced a “societal schizophrenia” as both “mother” and “prostitute” in a society that denied that one person could be both. Thus, women created a divide between work and home, separating social and sexual relationships that belonged in each sphere (Castañeda et al., 1996). Similarly, in the Dominican Republic, Kerrigan, et al, found a continuum separating “street” and “home,” where condom use was more common in “street” relationships, but less common in “home” relationships, which were characterized by family (and children) (Kerrigan et al., 2001). Ugandan women exhibited more complex and fluid identities, inhabiting

multiple identities at once, including that of mothers, but also “wives, partners, friends, and workers” (Zalwango et al., 2010).

### **6.3 *Methods***

Between February and July 2012, we conducted a qualitative study in Iringa and Njombe Regions, Tanzania, to explore FSWs’ experiences with motherhood. This was a sub-study of a strategic assessment to define a comprehensive response to HIV/AIDS in the area.

#### **6.3.1 Recruitment & Sampling**

A university-educated, female, Tanzanian research assistant with previous research experience underwent a two-week training on qualitative research and ethics before conducting recruitment and interviews. After gaining permissions from local leaders, she approached owners/managers of entertainment venues, explained the purpose of the study, and requested approval to recruit there. Women were then approached directly, informed about the study, and asked to participate. Additional women were contacted through snowball sampling.

Women were eligible if they were at least 18 years old, reported exchanging sex for money in the past month, and worked in entertainment venues (bars, clubs, etc.). Before each interview, the researcher read and explained an informed consent form and answered any questions before obtaining oral consent. Oral consent was used rather than written consent to protect confidentiality. Each participant chose a time and place for the interview that was convenient for her and allowed for privacy.

We used demographic and phenomenal purposive sampling (Sandelowski 1995);

specifically, we sought women to represent a range of ages, locations, and venue types; and also sought a range in numbers of children, including women with no children, and women who did and did not have children living with them. We recruited in different urban and semi-urban locations across Iringa and Njombe Regions in order to maximize any differences in types of work and clientele. Thus, rather than a representation of all FSWs in the area, these women represent a range of experiences.

### **6.3.2 Data Collection**

For the 30 FSW interviews, we developed an in-depth interview (IDI) guide with open-ended questions to direct questioning, but encouraged the interviewer to probe extensively. Topics included daily life, work experiences, reproductive history, motherhood, childcare, paternity, relationships, healthcare seeking, and health issues including HIV prevention and treatment. A similar guide was used for focus group discussions (FGDs). We conducted three FGDs with a total of 22 women (six, eight, and eight FSW participants) in three different towns.

Interviews were conducted in Swahili, audio recorded with permission, and transcribed verbatim. Identifying information was struck from the transcripts; we use pseudonyms in this paper. Within 24 hours of each interview, the interviewer wrote a summary of the interview, noting major topics, themes and methodological issues. We held weekly meetings during the course of data collection to discuss findings, troubleshoot, adjust language in the guides, and monitor variation in the sampling.

### **6.3.3 Analysis**

The first author read all transcripts in Swahili multiple times and added notes.

Additionally, we created a matrix to facilitate comparisons across participants on key quantifiable characteristics including location, venue type, age, education, reported HIV status, marital status, current and past intimate partnerships, condom use, and information about their children (number, ages, living situation, children's deaths, paternity). We used Stata/SE (version 12.0, StataCorp, College Station, TX) to calculate frequencies, means, and medians.

Next, the first author conducted thematic coding on the Swahili transcripts using Atlas.ti (version 7.0, Scientific Software Development GmbH, Eden Prairie, MN). We began the analysis with incident-by-incident coding to identify sections that concerned motherhood, childrearing, and information about children in general. Next, we conducted initial line-by-line coding on five transcripts, followed by axial coding to define categories and sub-categories among these initial codes. We identified one of these categories, how motherhood and childrearing might affect sex work, for further development in this paper. The first author then conducted detailed coding on sections previously coded as relevant to motherhood within all transcripts, allowing themes to emerge from the data, and explored them further using Query and Families functions. The first author also wrote memos on key themes throughout analysis to develop ideas (Charmaz 2006; Friese 2012). The first author translated quotations, and the interviewer checked them for accuracy.

We received ethical approval for this study from institutional review boards at Muhimbili University of Health and Applied Sciences, the Johns Hopkins Bloomberg School of Public Health, and the Tanzania National Institute for Medical Research.

## **6.4 Results**

### **6.4.1 Participant Demographics**

In-depth interviews were conducted with 30 women aged 20 to 40 (mean 28.9). They worked in various venue types, most (22/30) in bars (*baa* and *grosari*) that sold bottled alcohol, or small “clubs” (*kilabu*, plural *vilabu*) that sold locally brewed alcohol. Participants were recruited from five towns across two regions. None were currently married but about half reported intimate partners. Three-quarters had primary school educations. See Table 8. Without being asked, three women disclosed they were HIV-positive. Women had a median of two living children, and median age of children was seven years. At least three women were breastfeeding. Three women did not currently have living children. Of those with living children, two-thirds had at least one child living with them. Of these, 12 had children living alone with them, and others had help with childcare. See Table 9.

### **6.4.2 For the Children**

Many women had sole responsibility for their children’s material needs even if they did not live with them. Women saw this as extending their role as mothers to encompass the role of father/breadwinner. As one woman expressed, “I am the mother and the father” (Mpiluka, 33, Iringa, 1 child at home). In these circumstances, many found whatever work they could, including bar work, daily wage labor, farming, selling alcohol or prepared foods, and sex work. Mwajuma, for example, sold local brew for a USD1.25 profit per bucket. Considering that small profit, she said,



*Now you have children at home, and you live with your younger siblings, and you pay the rent, will that money be enough? Really, it will not be enough. So it is just surplus money, I mean...you purposely get clients and get money another way (Mwajuma, 34, Iringa, 1 child at home).*

Although sex work paid well compared to other jobs and allowed for independence and flexible work schedules, sex workers were stigmatized, and many expressed dislike for the work. As a woman said, “Maybe she’s doing it because of problems. There is no woman who likes exchanging money for sex” (FGD, Iringa & Ilula, Participant 5). She explained how the children’s needs could not be met through other work:

*Well, you can do other work. You can be doing a business. You are shocked that the business isn’t profitable....Maybe these children you have, their father left you ... If you look at home, these children want to eat, you want that you pay rent, I mean, you have to fulfill all the needs....A person tells you “Let’s go sleep together, I’ll give you a certain amount of money.” You must agree so that you get money to fulfill the children’s needs, you see? So that’s how, I think, you educate a child by using money of this kind, you see? But if you say, “You should educate the child without doing this action, you should stop,” that’s it, your children will just sit at home (FGD, Iringa & Ilula, Participant 5).*

Many other women echoed this motif of “for the children.”

*They do this...because they have small children...They do this so that their children live well and do not get problems. They get money so that they fulfill their children’s needs and their needs (Mariam, 22, Ilula, 1 child lived away).*

*If you have children, you have responsibilities (Estelle, 24, Iringa, 2 children at home).*

In contrast to the felt stigma many women expressed, one woman felt that society treated sex work “like normal work” *because* it was for the children.

*It [society] treats it like it's normal work, because, for example, I myself, now I do that work and I educate and take care of my family (Evangeline, 27, Mafinga, 2 children at home).*

Though some women expressed dislike for sex work, others reported feeling good about it since it enabled them to take care of the children.

*No, I cannot feel bad, because when he eats, he gets full, you understand? (Mpiluka, 33, Iringa, 1 child at home).*

One woman represents a negative case here; her work was not oriented around her children. Rather, “I have no goals other than to buy make-up, clothing, and food” (Shida, 28, Iringa, 1 child at home, 1 child away). She never wanted children, but bore two to avoid the stigma of childlessness. Nevertheless, she connected her sex work to feeding her child. When asked how she felt about bringing her infant to work with her, she replied,

*Now how will I feel, my sister? Don't I feel just great, because have I not gotten money for food? I have eaten and I feed the child well, she is developing great. I feel just great (Shida, 28, Iringa, 1 child at home, 1 child away).*

#### 6.4.2.1 Sex Work/Stigma; Motherhood/Respectability

Motherhood was idealized in Tanzania, and directly associated with respectability (*heshima*) and womanhood. For example, when asked what being a mother meant, Naiwa said,

*It brings respect. You know when you are called mother, it's really big praise.... To be called Mama of So-and-So is great respect. And when you are called Mama of So-and-So, already you are confident that "I am a woman who is completed" (Naiwa, 28, Mafinga, 3 children live away).*

This respectability contrasted to the stigma women faced as sex workers. Women expressed their felt stigma through concepts such as *kudharau* (to despise, to insult), *kuchukia* (to hate), and *aibu* (shame). Some also indirectly expressed their felt stigma through shy or nervous mannerisms during interviews; others used euphemisms to avoid saying they sold sex, e.g., "this action," "money of this kind," "get money another way." Most maintained that they went about their work in "secrecy," "hiding themselves" under the guise of respectable mothers and "regular women."

At health care centers, they reported being "treated like any other women" (Sofia, 26, Ilula, no children), and there, they dressed "with respect" and "like a mother" in long skirts, loose blouses, and *vitenge* (wraparounds). Dressed this way, "They cannot know I do this work" (Sofia, 26, Ilula, no children). This clothing contrasted sharply with the miniskirts, tight clothing, and other "shocking attire" they wore when seeking clients.

Although the respectability of motherhood was used to justify and to hide their sex work, one woman, Mwajuma, used respectability *within* her work to attract clients.

Quoting a proverb, she said, “Everything starts with clothing” (*Mavazi ndio chanzo cha yote*), and the right clothing could influence a man to “seduce you”:

*[Sex workers] for example wear really tight pants, or wear miniskirts. But if you have your respectability, then a man wants you. Even if you wear one kanga [wraparound] and a blouse, or two kanga, you drape yourself like this with wraparounds. But if this man tells me he likes me, and I have agreed [to have sex] with him, he just thinks, “This woman is just doing this kind of thing because of problems, but it’s not her character [hulka].” So it’s not necessary that you wear these shocking things (Mwajuma, 34, Iringa, 1 child at home).*

As seen in these quotations, women situated their socially stigmatized interactions at work within their respectable identities as mothers, doing whatever was necessary to care for their children.

#### **6.4.3 Motherhood, Power, and HIV Risk**

Being mothers affected sex workers’ negotiating power, reducing or compromising their power vis-à-vis clients in particular ways, while increasing it in other ways. This in turn led to both reported increases and decreases in HIV-related risks.

Motherhood constrained power in certain ways. First, a client could manipulate a mother’s concerns for her children. For example, a client refused to pay Chuki when she wanted to leave to prepare breakfast for her children. She told him,

*“Hold on, I must get the children ready to go to school.”*

*He told me, “One thousand. Prepare the children’s breakfast, then you come back.”*

*I told him, “I can’t come back.”*

*He said, “If you don’t come back, I won’t give you your money.”*

*I told him, “Enough, leave it.” Meaning, I left that place, I started a fire [for the children’s breakfast]. Now, should I leave and then go back again? (Chuki, age 38, Makambako, 2 children at home)*

Second, women considered their children’s needs when clients made offers, making them hard to refuse. Estelle explained:

*It’s like this in raising children. You will be shocked one day you wake up and truly you don’t have even ten [shillings], and right there you look at your child...and then if you see that you’ve woken up with only two thousand shillings to feed the children...oh! Tsk, that’s it, if a person happens to tell you “If you do this, I’ll give you such-and-such amount,” will you refuse? And if you look at home, you have no money? You agree just like that (Estelle, 24, Iringa, 2 children at home).*

These constraints led to increases in HIV-related risk behaviors, such as seeking more clients and unprotected vaginal and anal sex. Women specifically sought clients when they needed cash for their children’s expenses, since sex work paid much more than other work. Daily wage labor, for example, paid 400 to 1000 shillings (25-60 cents) for a full day’s work, while sex work paid 5,000 to 50,000 (USD3-30) or more per client. For Mpiluka, keeping her son in secondary school was a high priority, so she increased her client load as necessary to pay fees:

*Even at the bar I wasn’t drinking [to save money]....Don’t you know there are many college students these days? You find the college students are drunk, [I get] thirty [thousand shillings for sex with them] or whatnot, that’s how I sent my child to school (Mpiluka, 33, Iringa, 1 child at home).*

Likewise, if clients offered higher prices (usually double) for sex without condoms, mothers thought of their hungry children at home. A FGD participant described this situation:

*He will give me [the amount we agreed on], and we will go into the room there, we'll go to do that work. The work itself is just like this, there is no safety.*

*[I told him,] "I ask [that we use] a condom."*

*"A condom for what? Didn't you already take my money, so what do you want a condom for? I'll increase it with this other [money], take this here."*

*If I see I have children there at home dying from hunger, and I myself owe rent on the house, and I'm in the room, and I've already drunk his beer, and I don't have the money to repay him, it's just necessary that I agree and be hung out to dry (FGD, Makambako, Participant 8).*

Agreeing to anal sex was another compromise women made for their children. They preferred to avoid anal sex, but agreed since it fetched higher prices and they needed money for their children:

*You can meet with one who says, "I don't need, maybe, to have sex in front." Oh! He wants to do it behind?! So doing it like that just hurts, [but] because you want money, what will you do? And you have thoughts about your children...The children have no father, so you find that a thing like this just forces you [to agree]. You give it, so that you get money (Angel, 22, Ilula, 2 children at home).*

There were also ways in which motherhood empowered women in their work. First, women could appeal to their motherhood to earn extra money from clients. For example, sometimes long-distance truckers asked women to accompany them on long

trips, paying for their time and sexual services. Mother with children living away with relatives had more freedom to accept these multi-day trips, but women with children at home had to consider the costs of leaving them. Though some women simply refused overnight stays, others capitalized on the opportunity to ask for additional money they could leave with the children. Chuki explained:

*Maybe he's a driver, you will hear "I'm going on a trip to Tunduma, can you provide me company?" You will see if your schedule allows it. You tell him, "All right, but, my friend, I have a family." Yeah, if you say you have a family, "If we leave ten thousand, fifteen thousand, it can be enough for them." ...He gives you maybe fifteen thousand or twenty, and you leave it with the family. You go with him (Chuki, 38, Makambako, 2 children at home).*

Second, their motherhood gained FSWs sympathy from the police in disputes between themselves and their clients. FSWs often reported how clients agreed to pay a certain amount for sexual services, and then reduced the amount or denied payment once they were finished. Some women felt they could not approach police about this, but women in Makambako reported that police were helpful. One participant explained how the police sided with the women, partly because they have children.

*If we go to the [police] station, they speak like this [to the client], "This young woman had a problem that made her agree. It's not to say it was for her pleasure to sleep with you. She agreed in order to take care of her problems. You need to give her that money so that it can help her. It will be that she has children. She is supposed to prepare their breakfast right now. Now what will she cook this breakfast with?" So they help us at the station (FGD, Makambako, Participant 4).*

FSWs also used motherhood as a risk-reduction strategy. Participants were well aware of HIV transmission risks at work, and motherhood was a key motivation for women to protect themselves from acquiring HIV, or from developing or worsening their AIDS. Lusajo, for example, trusted no sexual partners in “these times of AIDS” because she had a family:

*There is no one whom I trust. You cannot trust your fellow humans...These times are different....These are the times of AIDS [UKIMWI]. First, Iringa surpasses [other regions] in AIDS....You need to be there to continue to watch your children, family. Yes, isn't it family? (Lusajo, 35, Iringa, 2 children at home, 1 away).*

Mothers explicitly connected condom use to their desire to protect their health so they can raise their children. For example, Chuki stated:

*And I try really hard to be attentive because I am a mother, and I have a family. I am supposed to take care of my family until...my time to live has ended. I try very hard to use condoms (Chuki, 38, Makambako, 2 children at home, 2 away).*

Likewise, Sara explained how she appealed to her motherhood to convince a regular client to use condoms.

*I cannot go with him without a condom [peku peku]. Truly, I told him, “Bwana, hey, the contraceptive [kinga] is right here.” He doesn't want it, even if I have a problem [have HIV]. [I tell him] “Bwana, go. I cannot lose my life. I cannot leave my children behind for your sake (Sara, 39, Makambako, 2 children lived away).*



The desire to use condoms did not necessarily translate into actual use; clients sometimes resisted this male-controlled method. Women commonly complained about clients resisting condom use—or forcing sex without condoms.

Having children who depend on them also increased women's desire to test for HIV. One woman described how she was encouraged to test when she accompanied an HIV-positive friend to the clinic. Thoughts of her child figured prominently into her reasoning:

*I was stubborn about testing [for HIV] ...But they [nurses] coaxed me to test, they told me "Sister, we request that you test." I told them, "And if I test and it shows I'm infected?" Now then, I was keeping in mind that first I have a small child. That child still depends on me .... If I die today, my child will suffer, and here I am without a father and without a mother ...And I went in and I tested (Agnes, 28, Iringa, 1 child lived away).*

These quotes from sex workers in Tanzania demonstrate how motherhood both increased and decreased HIV-related risk for FSWs.

## **6.5 Discussion**

Using the Theory of Gender and Power, we aimed to explore the intersections of motherhood and sex work, and how this impacted HIV-related risk behaviors among FSWs in Iringa and Njombe, Tanzania.

### **6.5.1 Gender, Power, Motherhood, and Sex Work**

We use the TGP to illuminate the gendered structures that patterned the lives of women who are both mothers and sex workers in Tanzania. Note that the four structures of gender (labor, power, emotional, and symbolic relations) are separated for analytic

purposes, but overlap and reinforce each other. Furthermore, these are not deterministic structures that demand robotic reactions; rather, they are patterns of how societies and institutions constrain people, and are (re)constituted through practice, so at the same time people resist and change them (Connell 2002), as the women in this study sometimes did.

According to the gendered division of labor in this study, an “ideal” mother stayed at home, attending to children and housework, supported by the husband/father as breadwinner. None of the women here, though, were currently married, and most had never married. However, they had an average of two children to support, performing the roles of both “the mother and the father.” Two-thirds of the women had children living with them, and others supported their children who lived away. Nationally only one-quarter of households were female-headed, and only 14% of children lived alone with their mothers (National Bureau of Statistics 2011). Female-headed households in Tanzania were more likely to be poorer and less likely to have enough food to eat (Katapa 2006). It is not the nature of female-headed households that makes them poorer; rather, it is the gender order which perpetuates inequalities in Tanzania that make meeting basic needs more difficult for women than men.

Labor options were limited for women. With fewer women than men finishing secondary school (National Bureau of Statistics 2011), and with children at home to support, women filled certain positions, such as bar work and sex work. (Male) bar managers hired young, attractive women as bar attendants to attract male clientele (Fischer 2013a), but paid the women too little to support families. Other work such as selling prepared food or alcohol was also gendered as “women’s work” and likewise paid

too little to support families. Mothers especially were attracted to the high pay and flexible working hours that sex work allowed, increasing client load as necessary to fulfill children's financial needs.

The women's situations in this study reflect the gendered division of power. Gender power figures prominently in other writing on sex work (Choi & Holroyd, 2007; Mbonye et al., 2012; Weine et al., 2013); what this paper adds is how gender power entered sex work in particular ways *for mothers*. In the socially expected "ideal" relationship, the woman had little power. In parallel, clients wielded considerable power over FSWs, first plying them with beer and food to demonstrate their earning power, then later sometimes denying them payment, refusing to use condoms, or threatening and using violence. This was seen in a quote above, where a client bought a woman dinner, and therefore had power over her; she was "hung out to dry" and felt forced to have sex with him, especially since her children were hungry.

This study also demonstrates gendered emotional relations. Here, the "ideal" attachment in which women's sexuality is to be confined—husband and wife—is somehow unachievable, or broken. Rather, the dominant emotional attachment for women in this study was between themselves and their children. This bond was so strong that she would do anything for them, such as go against prevailing norms about sexuality and face stigma. This dynamic is captured by the motif "for the children." This echoes how FSWs/mothers in Costa Rica justified their work to themselves and others as "for the children," giving them commodities and opportunities they themselves may not have had as children (Rivers-Moore 2010). In a financial sense, it was, indeed, for the children;

they paid for their children's food, clothing, and schooling. Symbolically, though, "for the children" was a discourse, a justification to themselves and others that their work was legitimate, despite being criminalized, "shameful," and "dangerous." By emphasizing that work was "for the children," sex workers were disassociating themselves from the stigma attached to their work by claiming the respectability that came with motherhood.

Lastly, the fourth dimension of gender, symbolic relations, figures prominently in this study, especially in what it means to be a woman, a mother, a wife, and a sex worker. Sex work was associated with AIDS and death, drunkenness, shame, promiscuity, and dressing and behaving in "shocking" ways; it meant scorn. Motherhood, on the other hand, was associated with womanhood, domesticity, marriage, and childrearing; it meant respectability (*heshima*). *Heshima* meant having "dignity, honor, and respect, as well as knowing how to properly extend courtesy and esteem to others" (McMahon 2005). One acquired, achieved, and maintained *heshima* through proper dress, behavior, decorum, and virtue.

Women in this study used the concept of *heshima*, which they achieved through motherhood, to counteract the stigma they felt from society against their work. Educating, feeding, and clothing their children was a way to prove the respectability that was being denied them by societal views on proper womanhood, single motherhood, divorce, and sex work. By dressing in particular ways, "with respect," (*kiheshima*) and "like a mother" (*kimama*), by "hiding," they desired to appear as "regular women" in society. For these women, being a mother *and* a sex worker meant taking care of the children, at whatever cost, including social sanction and risks to health. Like in Costa

Rica, “motherhood is central to sex workers’ ability to combat stigma” (Rivers-Moore 2010). This may be problematic for HIV transmission, however, if clients assume that women who emphasize their respectability have fewer partners and are therefore less risky as partners, and do not use condoms.

### **6.5.2 Motherhood, Sex Work, Power, and HIV**

The results indicate pathways through which motherhood directly increased HIV risk for FSWs, such as agreeing to unprotected vaginal and anal sex for more money. Any sex worker, mother or not, might make similar choices for a variety of reasons (or be denied the choice by a client). However, mothers in this study explicitly connected their HIV risk related decision-making to their children. In a choice between facing their hungry children tomorrow and risking exposure to HIV, women chose to feed their children. This pathway to HIV risk needs further research to understand how often this happens, and to what degree mothers may be at higher risk than non-mothers.

As in this study, FSWs in Kolkata, India, reported having to choose between earning money to feed their children and safeguarding their own health (Basu & Dutta, 2011). In Andhra Pradesh, India, FSWs with motherhood challenges were significantly less likely to use condoms consistently (AOR: 0.6), and more likely to accept more money for no condom during sex (AOR: 2.5) (Reed et al., 2012). Reed, et al, suggested two possible mechanisms in which motherhood affected risks. One, it could be the financial burden of supporting children that led to behaviors like accepting more money despite the health risks. Two, it could be that they had less time to work because of the demands of caretaking, and so accepted “riskier sex trades” (Reed et al., 2012). These

mechanisms were suggested by the FSWs in the present study, who reported increased risks associated with the financial burden of children and accepting (possibly riskier) clients.

In contrast to Reed's analysis, however, the women in this study also reported ways in which motherhood decreased their HIV-related risk behaviors. Women negotiated for higher prices by appealing to their children's needs, and used their motherhood to gain sympathy from police in disputes with clients. They also reported using condoms and testing for HIV to preserve their health for their children's sake, and negotiating for condom use by mentioning the children's welfare. FSWs in India and Latin American reported striving to protect their health so that they can stay healthy as their children grow. They saw their children as the most important thing in their lives, and were proud to be able to provide for them and give them brighter, educated futures (Basu & Dutta, 2011; Murray & MODEMU, 2002; Rivers-Moore 2010). It is possible these relationships with their children translated into safer HIV-related behaviors.

Mechanisms through which motherhood reduces HIV-risk behaviors should also be considered for further research to test whether, for example, *desires* for increased condom use (for the children) translates into *actual* increased use. Future research must also consider the complexities encountered here: motherhood may *both* increase and decrease HIV-related risk behaviors. This must be taken into account in epidemiological designs, as effects may be attenuated.

### **6.5.3 Limitations**

This study should be considered in light of its limitations. The data are cross-sectional; a longitudinal approach would have allowed for more time to ask follow-up clarification questions and delve more deeply into the nuances and complexities. Follow-up interviews would have also allowed time for building more rapport, which is important in interviews on these sensitive topics. However, the interviewer was a trained and experienced interviewer with a degree in counseling, and thus was able to encourage women to talk openly, and for the most part, they did.

Additionally, it is possible that women made judgments about what they thought the interviewer wanted to hear—she was associated with an HIV prevention project—and this could have influenced their answers. This phenomenon, called social desirability bias, rather than harming the validity of this study, gives an opportunity for reflexivity and provides a rich source of data. That women introduced social desirability bias (or controlled their narratives) provides important information about social expectations and norms, which was then analyzed as data in this study. For example, that woman talked about condom use and HIV testing indicated that they did, in fact, have knowledge about those things, and furthermore knew what they are “supposed” to do about them. However, women freely revealed stories about not using condoms, which suggests they felt able to reveal what they “really” did, rather than just what they were “supposed” to do.

### **6.5.4 Programmatic Implications**

This study has implications for future intervention programs for sex workers.

FSWs who were mothers in Mexico created a sharp division between their mother and sex worker roles. Thus, investigators recommended emphasizing the divide, suggesting that the condom could be the symbolic divider between their two worlds (Castañeda et al., 1996). The women in this study, however, interlaced their work lives with references and appeals to their children, emphasizing their motherhood, so a different approach may be needed. For example, programs should recognize the multifaceted aspects of FSWs' lives as workers, mothers, partners, and human beings, and how all of these aspects, roles, and identities overlap, intersect, and impact each other in complex ways.

FSWs who were mothers had financial and practical needs with regards to their children, which should be considered in programming. For example, FSWs engaged in risk behaviors such as agreeing to unprotected sex for more money, because their children were hungry. Programs could help women identify ways to earn more money for their children's basic necessities, help them access savings and loans programs, or form informal savings cooperatives among fellow FSWs to help in emergencies. Other ways to reduce the financial burden of children, such as connecting mothers to existing social services for themselves and their children, could also be explored.

Mothers were especially concerned about their children's educations, wanting them to finish at least secondary school so they could get good jobs and live "nice lives." Programs could provide support for children's educations, such as scholarships to pay for school fees, uniforms, etc. These programs could help reduce women's likelihood to accept riskier sex trades, and could empower them to refuse unwanted clients or unprotected sex acts. Additionally, childcare was an issue for many women, and placed



constraints on the times in which they could work, which may have increased HIV-related risk behaviors. Thus, programming should consider strategies to reduce the temporal burden on mothers, such as organizing 24-hour childcare, as in India (Basu & Dutta, 2011; Jana et al., 2004), or encouraging cooperative childcare among FSWs.

Finally, community mobilization and empowerment strategies among sex workers in India and Latin America have been successful at reducing HIV, reducing stigma, increasing women's self-efficacy, and advocating for their legal and human rights (Kerrigan et al., 2013). In India, these successful empowerment interventions credit part of their success to reacting to the women's needs as mothers, creating childcare services and advocating for children's educational rights (Basu & Dutta, 2011; Jana et al., 2004). Given the high proportion of FSWs who are mothers in sub-Saharan Africa, programming would do well to recognize FSWs' needs as mothers with children to support, in addition to more traditional HIV prevention and treatment strategies.

#### **6.5.5 Conclusions**

Sex workers who were mothers were well aware of risks they could encounter in their jobs, but with children at home to feed, clothe, and send to school, they were constrained in their choices. They explicitly connected their decision-making and HIV-related behaviors to their children. In some ways, this led to increases in risk behaviors, such as unprotected vaginal and anal sex; their children's hunger overcame their worries about the health risks. On the other hand, women could appeal to their status and roles as mothers as a way to achieve their ends, such as asking for higher payment or gaining

sympathy from police. Women also sought ways to protect themselves from disease for the sake of their children, including using condoms and seeking HIV testing.

In this study, women did not talk about the stigma they faced; rather, they talked about the respectability they were achieving. Perhaps rather than using the concept of “combating stigma,” which is etic, negative, and emphasizes the victimized other, sex workers’ complex realities can be better approached by using emic, positive concepts such as *heshima*, achieving respectability.

## 6.6 Tables for Chapter 6

**Table 8. Demographic Characteristics of Female Sex Workers (n=30)**

Characteristic	Value/Type	n	%*
Age (mean=28.9)	20-24	8	26.7
	25-29	10	33.3
	30-34	7	23.3
	35-40	5	16.7
Venue Type	<i>Baa</i> (large bar)	7	23.3
	<i>Kilabu</i> (bar with local brew)	14	46.7
	<i>Grosari</i> (small bar)	1	3.3
	Truck Stop	1	3.3
	Multiple Sites	7	23.3
Town (District, Region)	Iringa (Iringa Urban, Iringa)	12	40.0
	Ilula (Kilolo, Iringa)	9	30.0
	Mafinga (Mafinga Urban, Iringa)	3	10.0
	Kilolo (Kilolo, Iringa)	1	3.3
	Makambako (Makambako, Njombe)	5	16.7
Education	None	2	6.7
	Primary School	23	76.7
	Some Secondary School	5	16.7
Marital Status	Never Married	17	56.7
	Divorced/Separated	10	33.3
	Widowed	3	10.0

\*Percentages may not sum to 100 due to rounding.

**Table 9. Number & Living Situation of Children, per Woman (n=30)**

Characteristic	Value/Type	n	%
Number of Living Children per Woman Mean=1.7; Median=2	0	3	10.0
	1	9	30.0
	2	12	40.0
	3	6	20.0
Living Situation* (Woman had 1+ child(ren) living with:)	Mother Only <sup>§</sup>	12	40.0
	Mother + Other Relative	5	16.7
	Father	3	10.0
	Grandparent(s)	5	16.7
	Other Relatives	4	13.3
	No Children	3	10.0

\*Sum exceeds 100% because some mothers had children living in different households, e.g., one with her, and one with the father.

§ For living situation, the chart should be read “12 women had one or more children living with the mother only; 5 women had one or more children living with the mother plus another relative,” etc.

## **Chapter 7. Conclusions**

### **7.1 *Summary of Results***

This study explored female sex workers' reproductive lives, specifically their pregnancy experiences, contraceptive use, and how motherhood influenced their HIV-related risk behaviors at work. In total 30 women were interviewed in depth, and another 22 participated in three focus group discussions. Additionally, 13 people (health care workers, NGO staff, and bar owners/managers) were interviewed as key informants.

The 30 women in IDIs had mean age 28.9 years, with a range of 20-40 years. They worked in various venue types such as bars (*baa*, *vilabu*, *grosari*) and truck stops. The participants were spread across five towns and villages (Iringa town, Ilula, Kilolo, and Mafinga in Iringa Region, and Makambako in Njombe Region). None were currently married, though about half had intimate partners. Three-quarters had primary school educations, and five had some secondary school education. Without being asked, three women disclosed they were HIV-positive.

They also had a range of reproductive histories. Women had experienced between zero and six lifetime pregnancies, with a median of two. The range of living children was smaller, between zero and three, with a median of two (some mothers had had children die due to disease and injury). The 30 women reported 77 pregnancies in total, which resulted in 58 live births of 61 children (there were three sets of twins). All but one of the women had at least experienced pregnancy and childbirth. The one woman who had never been pregnant was included as a negative case to bring in a different point of view,

that of a sex worker who had no children, but nevertheless had views on pregnancy and sex work.

Women reported paternity of their pregnancies as well. Almost half of all the reported pregnancies occurred before initiation of sex work. About one-third of pregnancies (28/77 or 36.4%) were conceived with a husband, long-term cohabitating partner, or boyfriend who then became a husband/partner. Another five pregnancies (6.5%) were from casual, non-business sexual partners that did not lead the couple to marry/cohabit, and two pregnancies were the result of rape. Just over half of pregnancies were conceived during sex work, both with casual clients (22/77, or 28.6%), and with regular clients (18/77, 23.4%).

As women of reproductive age, FSWs had reproductive health needs, fertility intentions, and families. In turn, many of their intentions, desires, and healthcare needs overlapped with other women of the general population. However, given FSWs' work environments and the societal stigma against them, there are unique dynamics to consider, including the heightened risk of HIV and other STI. We aimed to illuminate some of those needs and dynamics, which must be understood to tailor interventions to meet their circumstances.

First, we highlighted several critical aspects of FSWs' social experiences with pregnancy that are important to consider in the context of reproductive health and HIV prevention programming. Women sought and had pregnancies with both intimate partners and clients for a variety of reasons. Unsurprisingly, the reasons FSWs sought pregnancy were similar to most women of reproductive age, such as the desire to have

families, to expand an already existing family, and “to be called Mama.” To be called Mama was a sign of respectability and “complete womanhood,” in direct opposition to the stigma of infertility, which was strong in Tanzania (Hollos & Larsen, 2008; Kielmann 1998), and FSWs were no exception to this social dynamic.

For FSWs, pregnancy was also used as a way to secure long-term relationships or more financial security. This dynamic reflects an argument Guyer made about West African “polyandrous motherhood” (Guyer 1994). She argued that through their children, women can make claims to inheritance, property and social capital, even long after their sexual relationships with the fathers end (Guyer 1994). Pregnancy, then, can be seen as a strategy, and bearing children with multiple men (“polyandrous motherhood”) can be advantageous to women, in that they can claim access to more social and physical capital. The FSWs in this study, like other women in Tanzania who did not have steady, long-term partnerships (Haram 2003), can be understood to be engaging in this kind of dynamic. FSWs in this study found varying degrees of success with these strategies, as some clients denied paternity while others incorporated mother and child(ren) as family.

These contexts in which FSWs intended and sought pregnancy had potential impact on their HIV-related risk behaviors. For example, some women targeted paternity to particular regular clients with whom they were building long-term relationships. This likely increased risk to some degree, particularly since the men had other partners, and women rarely reported discussing HIV status with their partners and clients. Other women reported a potentially riskier strategy: seeking pregnancy by having unprotected

sex with one or more casual clients, without discussing pregnancy intentions or HIV status with them.

Second, this study explored how FSWs used contraception, and how their contraceptive needs presented unique challenges that differ from women in the general population. In this study, FSWs wanted and used modern forms of contraception, and the methods they used matched the types most used in Tanzania; injectables, condoms, pills, and implants were most common (National Bureau of Statistics 2011). Other barrier methods such as diaphragms were unavailable, and although female condoms were available, none reported using them for contraception.

FSWs had reasons for contraceptive use that paralleled other women of reproductive age, e.g., delaying, spacing, and ending childbearing. Their work environments also led to additional reasons for contraceptive use. These included financial instability, and targeting paternity given multiple types of partnerships such as casual and regular clients as well as intimate partners. Thus, long-term methods may be inappropriate for women who want to prevent pregnancy with certain men but not others.

Although condoms were a readily available, reliable form of contraception, women's experiences at work caused them to distrust condoms as a contraceptive method. First, women feared condom breakage; when it had not happened to them personally, they had heard of it happening to others, and they feared its consequences for both HIV transmission and pregnancy. Second, FSWs simply did not trust in their clients' willingness to use condoms, and since condoms are a male-controlled method, and the gender order of Tanzania gave more power to men in sexual relationships, women could



at least take pregnancy prevention into their own hands. Unfortunately, other than female condoms, female-controlled barrier methods that FSWs could use selectively were unavailable.

There were neither clinical services nor national guidelines for HCWs to meet the specific medical needs of FSWs at the time of this study. HCWs reported treating FSWs “just like any other women,” which in some ways was a desirable outcome, especially if this meant FSWs did not face stigma and discrimination at health services, as has been reported elsewhere (Scorgie et al., 2013). However, this also meant that in the absence of guidelines or assessment of individual risks, FSWs unique needs were not being met. HCWs were unable to tailor services to FSWs’ circumstances, such as providing risk-reduction counseling, pre-conception counseling, ANC, PMTCT, and STI and violence screening.

Women in this study reported being discriminated against in ANC services if they presented for services without accompanying husbands. Seemingly in an attempt to encourage husbands’ participation in HIV testing during their wives’ pregnancies, health care providers were demanding women return to the antenatal clinic with husbands before they would test them for HIV. For FSWs in this study, none of whom had husbands, this was a significant barrier to services, and some women simply dropped out of care until the time of delivery. This is an alarming finding, as the pregnant women at highest risk for HIV were reportedly being denied HIV testing, a necessary step in prevention of mother-to-child transmission of HIV. This denial of care was contrary to

Tanzanian policy, which called for opt-out testing for all pregnant women (Tanzania Ministry of Health and Social Welfare 2012).

Likewise, FSWs presenting at family planning clinics were also treated “like any other woman,” which meant that selection and prescription of contraceptive methods was not tailored to FSWs’ needs and individual risks. Even in the case of family planning education given to FSWs in an intervention designed for FSWs, education about contraception was oriented toward married, monogamous women whose main concern was convincing their husbands to accept their use of contraception. Well-trained providers could assist women in finding the right (dual) methods for them given their condom (non)use, number of partners, risk and history of STIs, HIV status, and pregnancy intentions. For example, IUDs are inappropriate for women at very high risk for STI (World Health Organization 2010) and hormonal methods may increase HIV and STI risk (Delvaux & Buvé, 2013), but HCWs may prescribe these to FSWs, unaware of the women’s risks.

Women reported only rarely disclosing their occupations to healthcare providers, which precluded tailored care. This clinical silence was likely due to both societal stigma against sex workers and the legal status of sex exchange (Government of the United Republic of Tanzania 1981), but excludes a population at very high risk from the care they need. Even countries with generalized epidemics should focus on FSWs’ rights and access to health care, as an estimated 18% of HIV prevalence in the general female population in sub-Saharan Africa is attributable to (unsafe) sex work (Prüss-Ustün et al., 2013).

Lastly, we explored the intersections of motherhood and sex work, and how this impacted HIV-related risk behaviors among FSWs in Tanzania. Sex workers who were mothers were well aware of the risks they could encounter in their jobs, but with children at home to feed, clothe, and send to school, they were constrained in their choices. They explicitly connected their decision-making and HIV-related risk behaviors to their children. In some ways, this led to increases in risk behaviors, such as unprotected vaginal and anal sex; their children's hunger overcame their worries about the health risks. On the other hand, women appealed to their status and roles as mothers as a way to achieve their ends, such as asking for higher payment or gaining sympathy from police. Women also sought ways to protect themselves from disease for the sake of their children, including using condoms and seeking HIV testing.

This study employed the Theory of Gender and Power to analyze the gender regime of motherhood and sex work in Tanzania using four structures: labor, power, emotional, and symbolic relations. Labor options were limited for women in Tanzania, and this meant women filled certain positions, such as bar work and sex work; mothers especially were attracted to the high pay and flexible working hours that sex work allowed. Clients wielded considerable power over FSWs, first buying them beer and food to demonstrate their earning power, then later sometimes denying them payment, refusing to use condoms, or threatening and using violence. The dominant emotional attachment for women in this study was between themselves and their children. This bond was so strong that mothers would do anything for their children, such as go against prevailing

norms about sexuality and face stigma. This dynamic is captured by the motif “for the children.”

Symbolic relations figured prominently in this study, especially in what it means to be a woman, a mother, a wife, or a sex worker. Sex work was associated with AIDS and death, drunkenness, shame, promiscuity, and dressing and behaving in “shocking” ways; it meant scorn. Motherhood, on the other hand, was associated with womanhood, domesticity, marriage, and childrearing; it meant respectability (*heshima*). Symbolically, “for the children” was a discourse, a justification to themselves and others that their work was legitimate, despite being criminalized, “shameful,” and “dangerous.” By emphasizing that work was “for the children,” sex workers disassociated themselves from the stigma attached to their work by claiming the respectability that came with motherhood. In this study, women did not talk about the stigma they faced; rather, they talked about the respectability they were achieving. Perhaps rather than using the concept of “combating stigma,” which is etic, negative, and emphasizes the victimized other, sex workers’ complex realities can be better approached by using emic, positive concepts such as *heshima*, achieving respectability.

## ***7.2 Strengths and Limitations***

This study should be considered in light of its limitations. The data are cross-sectional; a longitudinal approach would have allowed for more time to ask follow-up clarification questions and delve more deeply into nuances and complexities. Follow-up interviews would have also allowed time for building more rapport, which is important in interviews on these sensitive topics. However, the interviewer was a trained and

experienced interviewer with a degree in counseling, and thus was able to encourage women to talk openly, and for the most part, they did.

Another limitation of this study is that healthcare experiences were self-reported by the women and HCWs, but no observations were made to ascertain actual practice. HCWs reported accepting and serving all healthcare clients, sex worker or not, but women reported some denial of services. This contradiction can be seen as a finding. Perhaps the women misunderstood HCWs' intentions around questions about the women's (non-existent) husbands, or perhaps HCWs reported expected behavior rather than actual behavior. Regardless of policy guidelines or actual practice, FSWs, as unmarried women, *felt* discriminated against in antenatal care, and this resulted in dropping out of care, which could put themselves and their fetuses at risk.

Considering the sensitive nature of the subject, HIV status was not asked during interviews. Only three women revealed they were HIV-positive, though others hinted that they were, and many disclosed recent negative test results. This limited potential comparisons between HIV-positive and HIV-negative FSWs. For example, only one FSW who disclosed her HIV-positive status expressed current fertility intentions, so while her experience was presented, no norms or expectations could be ascertained.

Understanding of contraceptive use is limited in this study. Contraception was but one of many topics within interviews; some women did not mention any contraceptive method whatsoever. Whether this was due to a lack of awareness, non-use, or simply due to not being directly asked during interview probes is unclear. It is telling that although the discussion turned on reproductive health, pregnancy, and childbearing among FSWs,

almost a third of women did not mention contraception at all. This can be seen as a finding in itself.

Additionally, it is possible that women made judgments about what they thought the interviewer wanted to hear—she was associated with a HIV prevention project—and this could have influenced their answers. This phenomenon, called social desirability bias, rather than harming the validity of this study, gives an opportunity for reflexivity and provides a rich source of data. That women introduced social desirability bias provides important information about social expectations and norms, which was then analyzed as data in this study. For example, that woman talked about condom use and HIV testing indicates that they did, in fact, have knowledge about those things, and furthermore knew what they are “supposed” to do about them. However, women freely revealed stories about not using condoms, which suggests they felt able to reveal what they “really” did, rather than just what they were “supposed” to do.

The interviewer-participant interaction influenced participants’ answers in other ways as well. For example, at the beginning of an interview, when asked what her typical day was like, one woman immediately answered that she did not like the work, but only did it for the children. This reaction implies the woman’s felt need to justify herself to the interviewer, and can mean the woman felt stigmatized for her work.

This study also has strengths. First, the lead author brought 14 years of experience researching in Tanzania to this study, and lived in the study site since before the study began, and throughout data collection, analysis, and writing. She also had 15 years of experience with the Swahili language, including four years of university-level Swahili

classes. This allowed a certain intimacy with the data, the study site, and the sociocultural context. In particular, this allowed her to read and analyze the data in the original Swahili, rather than wait for English translations that may have lost connotations, subtlety, and nuance. This closeness also enhanced the iterative process of research, where the research assistant and the author met at least weekly to make course corrections and explore new themes. The topic of contraception, for example, arose this way, and was more heavily emphasized in the remaining interviews.

Second, data was triangulated from multiple sources, including individual, in-depth interviews, focus group discussions, key informant interviews, as well as review of the literature, and informal sources such as daily conversations, visits to venues, attendance at programmatic activities and meetings, and involvement in other research in the study site. Earlier versions of Chapters 4 through 6 were presented at national conferences on family planning and key populations in the HIV epidemic, and received constructive criticism from attendees.

### ***7.3 Recommendations for Future Research***

Although this study adds to the research literature on reproduction among female sex workers, areas for further research remain. FSWs' needs as women of reproductive age overlap significantly with other women in the general population. However, the nature of their work environments presents some unique challenges.

More research is needed on the pregnancy prevention and planning needs of FSWs, such as pregnancy intentions and experiences, access to healthcare services, and pregnancy-related outcomes for both HIV-positive and HIV-negative FSWs. This study

found that FSWs were being denied care if they did not bring husbands to ANC clinics. In practice if not in policy, services discriminated against FSWs, none of whom happened to have husbands in this sample, and this likely applies to all unmarried women and adolescents. This finding, especially, needs further research to ascertain how widespread this practice is, as it has serious negative implications for the health of pregnant women and their fetuses. This is especially important for divorcees and widows, who are often economically and socially vulnerable, and have higher HIV prevalence than other women in Tanzania (24.7% in widows and 15.2% in divorced/separated women versus 5.2% in married women) (Tanzania Commission for AIDS (TACAIDS) et al., 2013).

Additionally, further research is needed to more fully understand the nuances of use, non-use, and discontinuation of contraception among FSWs, as well as the proportions of FSWs who use particular methods, their correlates and predictors. FSWs' contraceptive needs require attention to determine which methods are both the most appropriate given heightened HIV and STI risks, and which are acceptable to FSWs given their work environments and multiple types of partnerships. For example, research could be done on acceptability and feasibility of short-term, female-controlled methods that would allow women to selectively use contraception with certain partners. As such methods exist (e.g., diaphragms, female condoms), implementation research is needed on how to best promote access and uptake. Continuing research on safe and acceptable microbicides is also critical for FSWs, as is continued research on hormonal contraception's relation to HIV acquisition and transmission, as any effect is most likely to impact high-risk populations such as FSWs in sub-Saharan Africa.



Research on the maternal health of FSWs specifically, such as pregnancy outcomes, access to care, utilization of antenatal care, maternal morbidity and mortality, as well as neonatal outcomes, seems to be absent. This study found that about half of the women's pregnancies were conceived with clients, but little is known about what impact different paternity may have on a fetus or child. For example, it is unknown whether paternity through a client versus a regular partner affects the pregnancy (does it have worse birth outcomes?); the mother (does she have higher maternal morbidity risk?); or the child (is the child treated differently than siblings?).

This study also highlighted some relationships between motherhood and HIV-related risk behaviors among FSWs, but much is still unknown. Whether or not mothers' *desires* to protect themselves for the children's sake translate into *actual* increased condom use, for example, is unclear, but testable. This study demonstrated that motherhood could be both a protective factor and a risk factor, and this should be considered in epidemiological research, as effects could be attenuated by the multidirectional nature of the construct. Nevertheless, logistic regression models with numbers of children as predictor and consistent condom use as outcome could provide valuable information about the differential rates, if any. Even better would be longitudinal models that followed women over time, so that relative risks could be measured rather than correlates and odds.

An abstract, nuanced concept like motherhood is difficult to quantify as a predictor in a regression model, but there are powerful methods such as structural equation modeling that can be used to better understand the complex relationships at

play. The psychosocial statistical method latent class analysis could be especially powerful in categorizing women into “classes” of risk levels based on their actual behaviors, rather than on categories imposed on them from the outside, such as sex worker, woman engaged in transactional sex, or barmaid. These differentiations are often motivated and informed by political factors and moral judgments rather than empirical data about actual risk levels.

There are many other findings that could only be touched on in this dissertation, but deserve more attention. Condom breakage, for example, was a salient challenge for FSWs, but how often this actually occurred is unknown. It could be that women exchanged stories about condom breakage because it was so unusual and frightening, rather than because it was common. After all, the most common occurrence—condoms working perfectly—is a “non-story” not worthy of sharing (Gilovich 1993). However, even if uncommon, women feared it and some therefore distrusted condoms; this deserves more in-depth research. This same logic applies to side effects of contraception: they are rare but scary and therefore told and re-told, leading to distrust and non-use.

Other topics from the study that could not receive attention here but should be researched more in-depth both qualitatively and quantitatively as appropriate include the following: HIV prevalence and incidence; STI (rates, perceptions, and healthcare seeking and access); experiences of HIV-positive FSWs; unwanted pregnancy and abortion; the role of alcohol in sex work; differences in risk across venue types; self-efficacy in negotiations on price, desired sex acts, and condom use; clients’ perceptions on condoms, prices, and power in paid sexual encounters; clients’ physical, sexual, and verbal violence

against FSWs; the needs of children of FSWs; how sex work affects family; cooperation and competition between FSWs; the roles of managers/owners of entertainment venues; mobility and migration; interactions with police and the justice system; and potential for community mobilization and empowerment among FSWs in sub-Saharan African settings.

## **Chapter 8. Policy & Programmatic Recommendations**

As seen in this study, the contexts in which female sex workers live and work are complex, and their lives as women and mothers have impacts on their work and HIV-related risk behaviors. Thus, looking beyond the individual-level risks to the gendered structures and the social environments in which FSWs live and work is important to understand the various factors that impact FSWs' abilities to protect themselves. In turn, this knowledge can inform policy and programmatic interventions for FSWs. Based on the findings of this study, the following are some recommendations that target multiple aspects of FSWs' social environments and structures in which sex work occurs. These recommendations speak to HIV-related risk behaviors, but also to sex workers' broader lives and rights as workers, women, mothers, and human beings.

### **8.1.1 Health Interventions for FSWs as Individuals**

Many interventions for FSWs have focused on the individual level, taking a disease-focused approach targeting HIV prevention education, condom promotion, and STI screening and treatment, but with limited impact (Kerrigan et al., 2013). In Tanzania, these types of interventions for FSWs operated, including condom promotions and demonstrations and mobile HIV testing programs in bars and for FSW groups, and social marketing of condoms. Such HIV-prevention programs are essential, but could also expand to include other health needs that are not being well met for FSWs through health services for the general population. In particular, FSWs in this study revealed needs related to contraception, pregnancy planning and care, HIV treatment, STI, and gender-based violence (GBV) from clients. Furthermore, these types of interventions would be

more effective if they are a part of a multi-level approach that targeted the social environment and structures in which FSWs live and work, such as the following interventions.

### **8.1.2 Interventions for FSWs as Mothers**

This study highlighted FSWs' relationships to their children, and how women interlaced their work lives with references and appeals to their children, emphasizing their motherhood. This has implications for intervention programs. For example, programs should recognize the multifaceted aspects of FSWs' lives as workers, mothers, partners, and human beings, and how all of these aspects, roles, and identities overlap, intersect, and impact each other in complex ways. FSWs who were mothers had financial and practical needs with regards to their children, and these impacted their HIV-related risk behaviors, so these needs should be considered in programming. For example, FSWs engaged in risk behaviors such as agreeing to unprotected sex for more money, because their children were hungry. Programs could help women identify ways to earn more money for their children's basic necessities, help them access savings and loans programs, or form informal savings cooperatives among fellow FSWs to help in emergencies. Such informal savings cooperatives already operate in the area, including among FSWs, and help especially with emergencies such as funerals and hospital expenses. Other ways to reduce the financial burden of children such as connecting mothers to existing social services for themselves and their children could also be explored.

Mothers in this study were especially concerned about their children's educations,

wanting them to finish at least secondary school so they could get good jobs and live “nice lives.” Educational policies and fiscal realities meant families had to pay fees for tuition and supplies, which was an enormous burden and kept many children out of secondary school. Policies that reduce or eliminate cost sharing for at least the poorest families could help, and programs could provide support for children’s educations, such as scholarships to pay for school fees, uniforms, etc. These programs could help reduce women’s likelihood to accept riskier sex trades, and could empower them to refuse unwanted clients or unprotected sex acts.

Additionally, childcare was an issue for many women, and placed constraints on the times in which they could work, which may have increased HIV-related risk behaviors. Thus, programming should consider strategies to reduce the temporal burden on mothers, such as organizing 24-hour childcare, as was successfully done in India (Basu & Dutta, 2011; Jana et al., 2004), or encouraging cooperative childcare among FSWs. Informal cooperative childcare already existed among FSWs in this study. For example, one woman who had no children lived with two other FSWs who were mothers; they all took turns providing childcare in the evenings while the others went out to work. Expansions of affordable preschool and day care options might also help women work without the worries of leaving children unattended at home, and reduce pressure on them to earn more money through riskier sex trades in the reduced time they have. Given the high proportions of FSWs who are mothers in sub-Saharan Africa, programming should recognize FSWs’ needs as mothers with children to support, in addition to HIV prevention and treatment strategies.

### 8.1.3 Interventions for FSWs and their Clients

Besides their relationships with their children, relationships with clients and intimate partners greatly impacted FSWs' HIV-related risk behaviors, as has been found elsewhere (Kerrigan et al., 2001). While some FSWs in this study mentioned discussing HIV status with their clients and partners, many did not. Some even assumed that if a man did not insist on condom use, he must be HIV-negative, and if he did, it must be because he "had a problem" (*ana matatizo*), e.g. was HIV-positive. Thus, programs could promote HIV testing in venues for both clients and workers, and social marketing and mass media campaigns could promote communication between all sexual partners and make knowing one's status normative.

Since men often wielded greater power in FSW-client interactions, as seen here and elsewhere (Mbonye et al., 2012; Wingood et al., 2000), clients and men in general should be targeted for interventions. Women in this study reported that men offered more money for unprotected vaginal and anal sex, and because of their children, women were often tempted to accept, despite the known risks. One way to intervene is to change men's social norms on condom use. For example, Barrington, et al, described a condom intervention that used men's social networks to increase condom use among FSWs' clients (Barrington et al., 2009).

Women in this study also reported cases of verbal, physical, and sexual violence from clients, including gang rape and murder. At the time of this study, GBV programs in the area focused on reconciling married couples (in practice, if not in policy). To effectively serve FSWs, this must also include screening and treatment for violence from clients as well as intimate partners. Laws and policies on rape should also be reexamined

and enforced ("Tanzania Non-governmental Organizations' Shadow Report to CEDAW: The Implementation of the Convention on the Elimination of All Forms of Discrimination Against Women," 2008).

Though it was beyond the scope of this study to explore in depth, there was indication in interviews that anal sex was considered an HIV-prevention strategy, e.g. people engaged in anal sex partly because they believed it could not transmit HIV. Programs that target clients should include accurate information about anal sex and the importance of using condoms for all anal and vaginal sex acts.<sup>3</sup>

#### **8.1.4 Interventions for the Healthcare System**

Though FSWs in this study did not report significant discrimination in healthcare settings, they did fear being stigmatized and so did not disclose their sexual behaviors and risks, precluding appropriate care. Reproductive health interventions including but not limited to ANC, PMTCT, and family planning must be tailored to fit FSWs' unique contexts. For example, selection and prescription of contraceptive methods needs be tailored to FSWs' needs, fertility desires, and individual risks. This should be accompanied by appropriate, respectful counseling to help them choose the best methods for them, and a wider variety of modern methods could be made available to FSWs through outreach or other appropriate programs. Healthcare workers also could benefit from sensitization training on how to treat FSWs with respect and dignity, including

---

<sup>3</sup> Anal sex was criminalized in Tanzania, as in most former British colonies, as "carnal knowledge against the order of nature," *kinyume ya maumbile* in Swahili. While this is usually only enforced against men who have sex with men, the penal code does not differentiate on sex, and could also be used against women. Furthermore, it does not specify age or consent, e.g. anal sex between two adults is legally the same as anal sex between an adult and a child, and anal rape is legally the same as consensual anal sex (Government of the United Republic of Tanzania 1981; Human Rights Watch & WASO, 2013). This legal status may prevent FSWs from seeking care and/or accusing men in anal rape cases.



according them the privacy and confidentiality they deserve.

Women in this study reported barriers to ANC services, specifically because of presenting for services without accompanying husbands. According to participants, this requirement for a husband was new, though it is not clear where it originated. The Tanzanian MHSW guidelines encouraged but did not require an accompanying partner, and stipulated provider-initiated opt-out testing for *all* pregnant women (Tanzania Ministry of Health and Social Welfare 2012).

This focus on partners speaks to, and may be a result of, the international push for bringing men into care, particularly in the form of couples HIV testing and counseling (CHTC) services. There is sound reasoning behind this effort (World Health Organization 2006, 2012), and there is evidence for the health benefits of couples-oriented services (Aluisio et al., 2011). However, this study presents evidence of potential unintended negative consequences of well-intentioned ANC/CHTC policies. In practice if not in policy, services discriminated against FSWs as unmarried women. (None of the women in this sample happened to have husbands, though many FSWs do.) Moving forward, guidelines should be clarified to address this issue and practitioners should be sensitized to the context-specific applications of when couples care is and is not appropriate.

At the time of writing, Tanzania was drafting national guidelines for healthcare services for FSWs and other key populations in the HIV epidemic. This is essential to ensuring non-discriminatory services related to HIV/AIDS, but guidelines should also include reproductive health issues, including contraception and ANC. National guidelines should also accommodate all women, not just married women, in reproductive health

services.

### **8.1.5 Interventions for Work Environments**

Work environments can also be targeted for interventions. As some women reported that clients tried to avoid condom use by claiming they were unavailable (which was sometimes true), cheap or free male and female condoms can be placed in areas where clients and FSWs both meet (bars) and have sex (guesthouses). Additionally, they can be made more available in healthcare settings and pharmacies, and venue owners/managers can be involved in promoting their use. A study from the Dominican Republic found that high support for condom use in the work environment (e.g., quality condoms available in the establishment; communication from the owner that condoms were to be used, etc.) was significantly associated with consistent condom use with regular paying partners (OR 2.16) (Kerrigan et al., 2003). Building on this, as part of a multi-level intervention, venue owners were asked to post pro-condom posters, keep condoms in prominent places, and keep a minimum stock of 100 condoms; condom use increased over the course of the intervention (Kerrigan et al., 2006). Such a program could be adapted to venues in places like Tanzania.

Even in the Tanzanian work environments where sex workers operate independently and venue owners/managers do not take a percentage of FSWs' earnings, owners/managers nevertheless have vested interests in and gain profit from having sex workers in their venues. For example, they prefer to have attractive, young women in their bars because they attract clientele who buy alcohol and food and rent rooms. Programs could work with owners/managers to help them realize the importance of

helping workers stay healthy, and develop a positive, workers' rights-based approach to aid in this. Also in the work environment, managers pay bar workers extremely low wages (about USD12 per month); advocacy for workers' rights could be helpful in this as well. It should be recognized, though, that managers/owners have interests in keeping workers' salaries low, and interventions should recognize them as stakeholders and find ways to work with them for lasting effect.

#### **8.1.6 Legal and Policy Interventions**

There are laws and policies that contribute to FSWs' vulnerability to HIV, so the government could address these issues by reviewing, enforcing, or changing certain policies and laws. First, the criminalized status of sex work (see Section 2.5.5) results in difficult working environments where women are stigmatized, discriminated against, and are victims of violence, all of which leads to HIV-related risk as well as other human rights violations. For example, the criminal status of sex work makes it easier for clients to violate sex workers' rights without fear of legal consequences, and makes FSWs unwilling or unable to take cases of clients' violence and theft to the police. This certainly was true for women in this study. However, there were also stories of police and judges who were sympathetic to sex workers when clients refused to pay for their services. These police and judges could be supported as positive deviants (Marsh, Schroeder, Dearden, Sternin, & Sternin, 2004) to model behavior that ultimately makes sex work safer for workers and clients alike.

Gender inequities lead to power differentials that favor men, confine women to low paying "women's work," and severally restrict women's abilities to make choices for

their own lives and livelihoods and protect themselves from HIV, STI and unwanted pregnancy. For FSWs, these inequities make it difficult from them to work safely, which ultimately increases HIV rates among them and in turn, in the general population. One way to address these gender inequities is at the national level, through actions such as complying with the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Although Tanzania is a signatory to CEDAW, many laws and customary laws remain that discriminate against women, including in marriage, divorce, custody, and inheritance ("Tanzania Non-governmental Organizations' Shadow Report to CEDAW: The Implementation of the Convention on the Elimination of All Forms of Discrimination Against Women," 2008). Tanzania should continue to work toward changing laws to comply with CEDAW, reducing laws and policies that discriminate against women, implementing and enforcing anti-discrimination policies, supporting girls' education at all levels, and promoting gender equality as a social norm. This will make it easier for all women, including FSWs, to live their lives as they choose.

#### **8.1.7 Community Mobilization and Empowerment for FSWs**

Lastly, an important and effective type of intervention that targets multiple factors in the social environment is community mobilization and empowerment among sex workers. Several of these interventions among (both female and male) sex workers in India and Latin America have been successful at decreasing HIV rates, reducing stigma, increasing self-efficacy, and achieving sex workers' legal and human rights (Kerrigan et al., 2013). These interventions, in addition to the individual, disease-focused interventions mentioned above, also share "key principles and processes...including the

recognition of sex work as work, the creation of a safe space for sex workers to gather and organize, and the stimulation of sex workers' individual and collective agency to address inequitable social structures which impact their health, well-being and ability to protect themselves from HIV" (Kerrigan et al., 2013).

Although no interventions of this type have been implemented in sub-Saharan Africa (Kerrigan et al., 2013), this study found some indications that FSWs in Tanzania would support and benefit from community mobilization and empowerment interventions. For example, associations called *chama* (plural: *vyama*) are already a well-known, grassroots social institution formed for social, moral, and financial support among people sharing something in common (Tsuruta 2006), such as a profession. Translated variously as guild, party, or club, *chama* carries the connotation of being participatory and community-led, key elements in mobilization efforts elsewhere (Jana et al., 2004; Kerrigan et al., 2013). A group of FSWs in one of the study sites had formed such a *chama*, indicating that they were not only willing to mobilize, but that they were willing to mobilize *as sex workers*, using the label *madada poa*.

The label *madada poa* itself is another indication that mobilization is possible; unlike other terms for sex work, this term was not derogatory, and was favored by sex workers themselves. It hints at a certain level of social identity and conscientization (Murray, Lippman, Donini, & Kerrigan, 2010) that could be built upon. Additionally, as mentioned above, some FSWs were willing to disclose their occupations to members of the justice system, which was sometimes met with supportive reactions, indicating that legal advocacy for FSWs may be well met. Community empowerment interventions can

further encourage FSWs to speak freely with healthcare providers about their risks and needs, to monitor and provide feedback on the quality of services provided to them as a community, and to demand their rights in healthcare and beyond.



*Figure 3 Map of Iringa and Njombe Regions, Tanzania, East Africa*

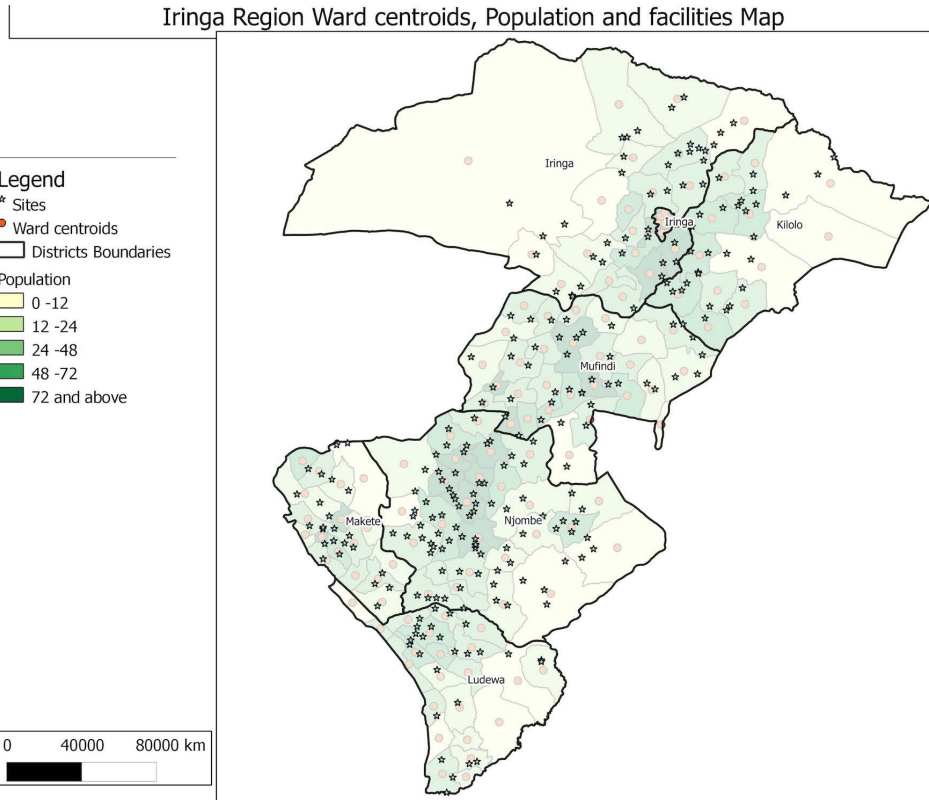


Source: Adapted from [http://commons.wikimedia.org/wiki/File:Tanzania\\_Iringa\\_location\\_map.svg](http://commons.wikimedia.org/wiki/File:Tanzania_Iringa_location_map.svg)



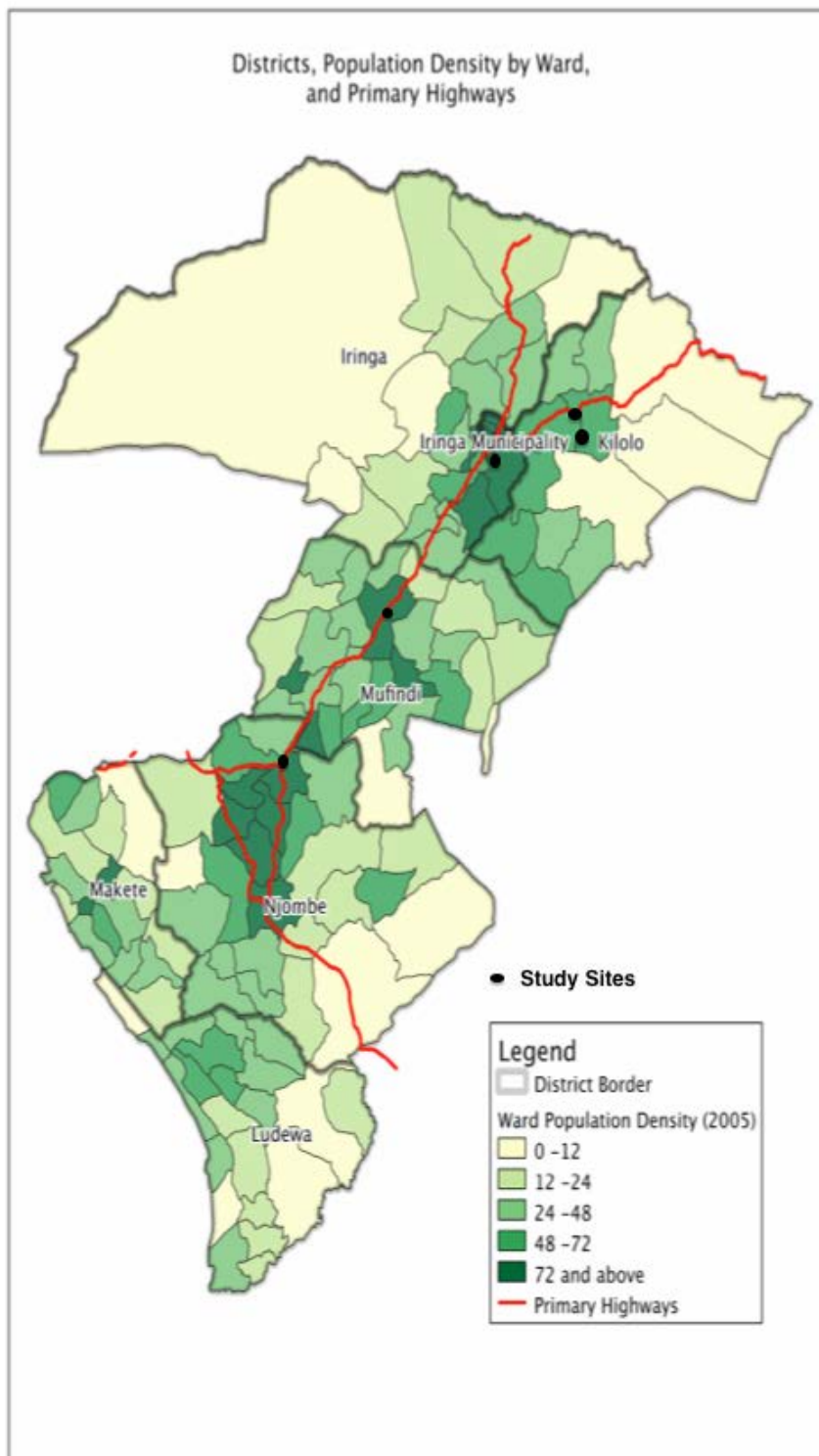
Figure 4

Map of Health Care Facilities in Iringa and Njombe Regions



Source: MEASURE Evaluation 2011

Figure 5 Map of Iringa and Njombe Regions, with Major Highways and Study Sites



Source: MEASURE Evaluation Tanzania, 2011, compiled by Justin Beckham

## 9.2 Appendix 2: Venues

Note: The following are pictures of types of venues in Iringa and Njombe Regions, but are not where FSWs were recruited for this study.

Figure 6 Venues: Vilabu or “Local Bars” (top, middle) and Ulanzi (Bamboo Wine) (bottom)



Figure 7      *Venues: Baa or “Modern Bars”*



Figure 8 Venues: Grosari (Grocery) or Small Bars





*Figure 9 Venues: Truck Stops*



*Figure 10 Venues: Guesthouses*



*Figure 11 Venues: Disco*



Photos: Justin Beckham, Sarah Beckham

### 9.3 Appendix 3: Data Collection Instruments

**Table 10. List of Data Collection Instruments**

Title	Population	Type	Language
1. Interview Guide for Sex Working Mothers	Female Sex Workers	IDI	English
2. Interview Guide for Sex Working Mothers	Female Sex Workers	IDI	Swahili
3. Additional Questions for Sex Worker Interviews	Female Sex Workers	IDI	English/Swahili
4. Pictures for Expenditures Exercise	Female Sex Workers	IDI	NA
5. Map for Mapping Exercise	Female Sex Workers	IDI	Swahili
6. Focus Group Guide for Sex Working Mothers	Female Sex Workers	FGD	English
7. Focus Group Guide for Sex Working Mothers	Female Sex Workers	FGD	Swahili
8. Revisions to Guide for Sex Workers	Female Sex Workers	FGD	English/Swahili
9. Interview guide for Key Informant Interviews: NGO Workers	NGO Staff	KII	English
10. Interview guide for Key Informant Interviews: NGO Workers	NGO Staff	KII	Swahili
11. Interview guide for Key Informant Interviews: Health Care Workers	Health Care Workers	KII	Swahili
12. Interview Guide Adapted for non-NGO/non-HCW Key Informants	Bar Owners & Managers	KII	English





Approved: June 15, 2011  
IRB No.: 00003616

Page 1 of 3

## JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

### INTERVIEW GUIDE

#### Interview guide for Sex Working Mothers

**PI:** Dr. Caitlin Kennedy

**Study Title:** Strategic Assessment to Define a Comprehensive Response to HIV in Iringa, Tanzania

**IRB No.:** IRB00003616

**PI Version Number/Date:** Version #1\_May 9, 2011

---

#### SOCIO-DEMOGRAPHICS

1. ID Code: Assign ID
2. Age: Age in years
3. Education: Highest level of school
4. Live with: Document household members
5. Birthplace: City/country of origin

#### INTRODUCTION

Thank you for talking with me today. We appreciate your time in helping us understand the experiences of sex workers. The information you provide today will remain completely confidential and will be helpful to design future programs to support sex workers in Iringa.

#### INTERVIEW GUIDE

1. I'd like to start by learning a little bit more about you. What is a typical day like for you?  
Probe: What do you do in the morning when you wake up, what household and childcare chores do you do, how do you get your meals, when do you work, who do you visit with, etc?
2. Could you please tell me about your typical work day?  
Probe: Where do you go? When? Who do you meet? How do you get clients? How many?
3. Who are your friends? What makes them your friends?
4. What kinds of things would you ask your friends to do for you?  
Probe: give money, watch children, care for me when sick

Strategic Assessment to Define a Comprehensive Response to HIV in Iringa, Tanzania.  
IRB No.: IRB00003616 PI: Dr. Caitlin Kennedy V1 / May 9, 2011



Approved: June 15, 2011  
IRB No.: 00003616

Page 2 of 3

5. Who do rely on when you need extra money? What kinds of things do you need extra money for?
6. Tell me about contact with your family of birth.  
How far away are they? Do you interact with them, such as call them, send them money, go home for weddings and funerals?
7. Tell me about your father.  
What was he like? How did he take care of you?
8. Tell me about your mother.  
What was she like? How did she take care of you?
9. What does it mean to be a mother?  
What does a mother do? What are her roles?  
What makes a good mother?
10. Tell me about your siblings.  
How many of them are there? What do they do now? Do they know what you do for work? How do they/would they think about that?
11. How many pregnancies have you had?
12. What happened with each of those pregnancies?  
Probe: pregnancy loss, still birth, neonatal death, under 5 death, still living
13. Where is each of the living children now?  
Are any of them living with you?
14. Who was the father of these pregnancies?
15. Think about a day when something happened that you will always remember.  
Can you tell about that? What happened? Who was there? Why do you remember it?
16. Think about a day when something happened *when you were (sex) working* that you will always remember.  
Can you tell about that? What happened? Who was there? Why do you remember it?
17. What kinds of sexual partners are there?  
Probe: *mpenzi, mchumba, bwana, boyfriend, mme*
18. What are the differences between the types of partners? What makes a man one type of partner and not another?
19. What is transactional sex? [elicit and use local term] How is it different from sex work?
20. What makes sex *sex work*?
21. What are all the words for women who exchange sex for money?
22. What does *umalaya* [and other words for sex work that they name] mean? Who is a *malaya*?

Strategic Assessment to Define a Comprehensive Response to HIV in Iringa, Tanzania.  
IRB No.: IRB00003616 PI: Dr. Caitlin Kennedy V1 / May 9, 2011



Approved: June 15, 2011  
IRB No.: 00003616

Page 3 of 3

23. What kind of man goes with a sex worker?
24. What kinds of things will they do together, beyond sex?
25. What are the kinds of challenges and problems do SWs face?  
Which of these are more and less serious?  
Which of these are more and less frequent?
26. What are the particular challenges SWs face in also being mothers?
27. What does the community think of sex workers? How do they view you and treat you?
28. What kinds of health problems do SWs face?  
Probe: HIV, STI, infertility, pregnancy, unwanted pregnancy, pregnancy by a client, violence/injury
29. What is it like to go to a health clinic?  
How are sex workers treated at clinics?  
Probe: differences between public, private, faith-based clinics
30. Is there anything else you would like to tell me about the topics we have discussed today?

That is the end of our interview. Do you have any questions for me?

We appreciate your honest answers to our questions. Thank you for your time.



Approved: June 15, 2011  
IRB No.: 00003616

Page 1 of 3

**MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES (MUHAS)**

**JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH (JHSPH)**

**INTERVIEW GUIDE**

**Interview guide for Sex Working Mothers**

**US-based Principal Investigator:** Caitlin Kennedy (JHSPH)

**Tanzania-based Principal Investigator:** Jessie Mbwambo (MUHAS)

**Study Title:** Strategic Assessment to Define a Comprehensive Response to HIV in Iringa, Tanzania

**IRB No.:** IRB00003616

**PI Version Number/Date:** Version #1\_May 31, 2011

---

**DEMOGRAFIA ZA KIJAMILI.**

1. Namba ya Utambulisho: Weka namba
2. Umri: Umri kwa miaka
3. Elimu: Kiwango cha juu cha elimu
4. Unaoishi nao: Wasajili wana kaya.
5. Mahali pa kuzaliwa: Mji/Nchi uliyozaliwa

**UTANGULIZI**

Asante kwa kukubali kuzungumza na mimi leo. Tunashukuru kwa muda wako katika kutusidia kuelewa uzoefu wa wafanyakazi wa ngono. Taarifa uliyoitoe leo itabaki kuwa siri kabisa na itasaidi kuunda programu za baadaye za kuwasaidia wafanyabiashara ya ngono hapa Iringa.

**MWONGOZO WA USAILI**

1. Ningependa kuanza kwa kujifunza zaidi kuhusu wewe. Je siku ya kawaida inakuwaje kwako?  
Dadisi: Asubuhi ukiamka huwa unafanya nini, Ni kazi gani za nyumbani na zakulea watoto unazozifanya, unapataje mlo wako, ni wakati gani unafanya kazi, unamtembeleaga nani, n.k.
2. Tafadhali unaweza kuniambia kuhusu siku ya kawaida ya kazi?  
Dadisi: Huwa unaenda wapi? Wakati gani? Unakutana na nani? Unapataje wateja? Wangapi?
3. Nani ni marafiki zako? Ni kitu gani kinawafanya kuwa marafiki zako.

Strategic Assessment to Define a Comprehensive Response to HIV in Iringa, Tanzania.  
IRB No.: IRB00003616 PI: Dr. Caitlin Kennedy V1 / May 31, 2011



Approved: June 15, 2011  
IRB No.: 00003616

Page 3 of 3

21. Ni maneno yapi yanayotumika kwa wanawake wanaobadili ngono kwa pesa?
22. *Umalaya* [na maneno mengine ya kazi ya ngono wanayoyataja.] unamaanisha nini? *Malaya ni nani?*
23. Je, ni mwanaume wa aina gani anatembea na mfanya bishara ya ngono?  
.
24. Je, zaidi ya ngono , ni mambo gani wanayofanya pamoja?
25. Ni aina gani ya changamoto na matatizo wanayoyapata wafanyabiashara za ngono?  
Kati ya hizi ni zipi ambazo zimezidi na ambazo zimepungua kwa ukubwa.  
Kati ya hizi ni zipi zimezidi na ambazo zimepungua kufanyika?
26. Wafanyabiashara za ngono ambao pia ni akina mama wanakumbana na changamoto gani hasa?
27. Jamii inafikiri nini kuhusu wafanya biashara ya ngono? Wanakuonaje na wanakutendeaje?
28. Wafanya biashara ya ngono wanapata matatizo gani ya kiafya?  
Dadisi: VVU, magonjwa ya zinaa, utasa, mimba, mimba zisizotakiwa, mimba kwa wateja, kupigwa/kujeruhiwa
29. Inakuwaje wakienda kliniki?  
Wafanya biashara ya ngono hufanyiwa nini katika kliniki?  
Dadisi: Tofauti kati ya kliniki za umma, kliniki binafsi, kliniki zenye misingi ya kiimani
30. Kuna kitu kingine ambacho ungependa kuniambia kuhusu mada tuliyoijadili leo?
- Huu ndiyo mwisho wa usaili wetu. Unaswali lolote kwangu?
- Tunashukuru kwa majibu yako ya uaminifu kwa maswali yetu. Asante kwa kutoa muda wako.

## **Additional Questions for Sex Worker interviews**

[New section:]

### ***Mapping Activity: Roles & Identities in Daily Life***

Now we are going to do a little activity. Here we have a map of places you might go in your life very day. For example, here is a house; let's pretend it is your house. And here are some other places, for example, where you work, where your kids go to school, where you catch the daladala [bus], where the kids go while you work, friends you visit, the market where you shop, places you go me meet friends, where you meet clients, where you get health care, where you go to church or pray, where the major roads are, etc. [Show the participant the places on the map.] Is there any other place you go that is not on this map? Ok, let's add it. Excellent. Now that we have a map, let's talk about it. For each place on the map, I will ask you some questions.

When you go here, how do you dress? What do you people call you? How do you act at that place? How do people treat you there? Who do you talk to there? What other people are there, or what kinds of people? What times of day do you go there? For what purposes do you go there? [repeat questions for each place on map]

Now, looking at the whole map again, at which places can you find children? [have her point to each place, then for each place she indicated, ask all questions:] What do the children do there? Are children supposed to be there? Do others find that it is normal or expected to see children there? Why or why not?

Now, looking at the whole map again, at which places do/did you earn money? [have her point to each place, then for each place she indicated, ask:] How do/did you earn money at that place? At which places do you spend money? [have her point to each place, then for each place she indicated, ask:] What kinds of things do you spend money on? For what purposes?

[new section:]

### ***Expenditures Activity***

[Women will be given fake money [colored papers with 100, 500, 1000, 2000, 5000, and 10,000 shillings written on them], and then several cans or papers representing different things to spend money on, such as pictures that show a bus, staple foods, non-staple foods, soap, children's medicines, adults' medicines, housing, children's clothing, women's clothing, cell phone vouchers [minutes], make-up, jewelry, school uniform, school books, alcohol, female condoms, and male condoms. The interview will explain the activity and demonstrate how to "spend" the money but putting it into/onto the different possible expenditures to represent how they would allocate money. Once the interviewer is sure the woman understands, they continue.]

First, let's pretend you had 20,000 shillings [\$12.50]. Here are some papers that we can pretend are shillings. Let's say it happens that you need all of these things, how would you spend that money? Why did you "buy" that?

Now, let's pretend you had 200,000 shillings [\$125]. Let's say it happens that you need all of these things, how would you spend that 200,000 shillings? Why did you "buy" that?

*For women who have children who do not live with them:* Where does the child live? With whom? Does she send money? How much? How often? Does she want the child to come live with her? How does she feel about the child living somewhere else, to have her child be away from her? How does she feel about her child being raised by someone else?

What does it mean to be a good mother? A bad mother? Do you feel like you are a good mother? Can you give an example of a good mother? A bad mother?

*For women who have children living with them:* What do the children do while you are at work? How old are the children? *If they have big children:* do they know what kind of work you do? What do they think about it? *If they keep it secret,* why? What do you think would happen if they found out?

*If they do not point to bar/vilabu/guesti on the map:* What about this place?

What hopes or goals do you have for your children? What do you want their lives to be like? What do you want them to accomplish?

Do FSW get unwanted pregnancies? What do they do? Do they ever get pregnancies they wanted, get pregnant on purpose? Why? Tell a story about that.

Do women who exchange money for sex every get pregnant from clients? What do they do then? Do you know anyone this happened to? What did she do (abort? Bear it?) Do women still exchange money for sex while they are pregnant?

Do women who exchange money for sex use family planning? What kinds?

What is the difference between *Mfanyabiashara ya ngono* [sex businessperson] *na kubadilishana pesa kwa ngono* [exchanging sex for money] *na kujiuza* [and to sell oneself]?

What challenges are there for FSW who are mothers, different from FSW who are not mothers?

[New section:]

### ***Mapping Activity: Roles & Identities in Daily Life***

*Sasa tunaenda kufanya zoezi dogo. Ningependa unichoree aina fulani ya ramani. Unaweza kuchora kwenye karatasi na kalamu, au tunaweza kutumia vijiti au kamba au vitu vingine tulivyo navyo hapa. Naweza kukuonyesha mfano ninachomaanisha. [Kama mhojaji anahisi huyu mwanamke hana uhakika wa jinsi ya kuchora ramani, anaweza kuchora ya kawaida na kumwelekeza hatua za kuchora.]*

*Ukienda hapa, unavaa je? Watu wanakuitaje? Huwa unakuwaje hiyo sehemu? Watu wanakuchukuliaje hiyo sehemu? Unaongea na nani pale? Kuna kuwa na watu gani*

wengine au watu wa aina gani? Huwa unaenda mda gani? Huwa unaenda kufanya nini?

Sasa, angalia ramani yote tena, sehemu gani unaweza kukuta watoto? [Mwaache aonyeshe kila sehemu, na kila sehemu anayoonyesha uliza maswali yote:] Watoto wanakuwa wanafanya nini hapo? Je watoto wanatakiwa kuwa hapo? Je watu wengine wanaona ni kawaida au wanategemea kukuta watoto hapo? Kwa nini au kwa nini sio?

Sasa, tukiangalia ramani yote tena, sehemu gani unapata pesa? [Mwaache aonyeshe kila sehemu, na kila sehemu anayoonyesha, uliza] Unapataje pesa sehemu hii? Sehemu gan unatumia pesa zako? [Mwaache aonyeshe kila sehemu, na kila sehemu anayoonyesha, uliza] Je vitu gani ambazo huwa unatumia hela? Kwa sababu gani?

### **Matumizi**

[Wanawake watapewa pesa bandia (karatasi zenye rangi na maandishi ya shilingi 100, 500, 1000, 5000 na 10,000), na makopo tofauti au karatasi zenye vitu mbali mbali ambavyo unaweza kutumia pesa kununua kama picha zinazoonyesha basi, vyakula, mboga, dawa za watoto, dawa za watu wazima, sabuni, nyumba, nguo za watoto, nguo za watu wazima, vocha za simu, urembo, herein, bangili, nguo za shule, vitabu vya shule, pombe, kondomu za kike na kondomu za kiume. Mahojiano yataeleza zoezi na mifano ya jinsi ya “kutumia” kwa kuweka juu ya vitu mbalimali kuonyesha jinsi gni wangetumia pesa. Mara mhojiwa atakapokuwa na uhakika kuwa mwanamke ameelewa, wataendelea.]

Kwanza, tujifanye una shilingi 20,000/= [\$12]. Hizi hapa nikaratasi ambazo tunawea kujifanya ni pesa. Tujifanye unahitaji hivi vitu vyote, utaitumiaje hii pesa? Kwa nini “umenunua” hivi?

Sasa, tujifanye una shilingi 200,000/= [\$120]. Tufanye unahitaji hivi vitu vyote, utatumiaje hii shilingi 200,000/= Kwanini “umenunua” hivyo?



Pictures for Money Exercise



nauli za daladala/bus fare\*



chakula/food



dawa za kitoto/ children's medicines



dawa/medicines



kodi ya nyumba/house rent



**sabuni/soap**



**maboga na matunda/fruits and vegetables**



**nyama/meat**



matofali na simenti/house building materials



nguo/clothing



vocha/phone credit



**vipodozi, pafuum/make-up, perfume, jewelry**



**nguo za shule/school uniforms**



**ada za shule/school fees**



daftari/notebooks for school



pombe/alcohol



kondomu za kike/female condoms



kondomu za kiume/male condoms





simu/phone



kuweka akiba benki/bank savings account



SACCOS/microfinancing



www.shutterstock.com 21581331

kuweka akiba/savings



kupelekea watoto/send money to children living away



huduma za kituo cha afya/health care





saloon/hair salon



mahitaji ya nyumbani





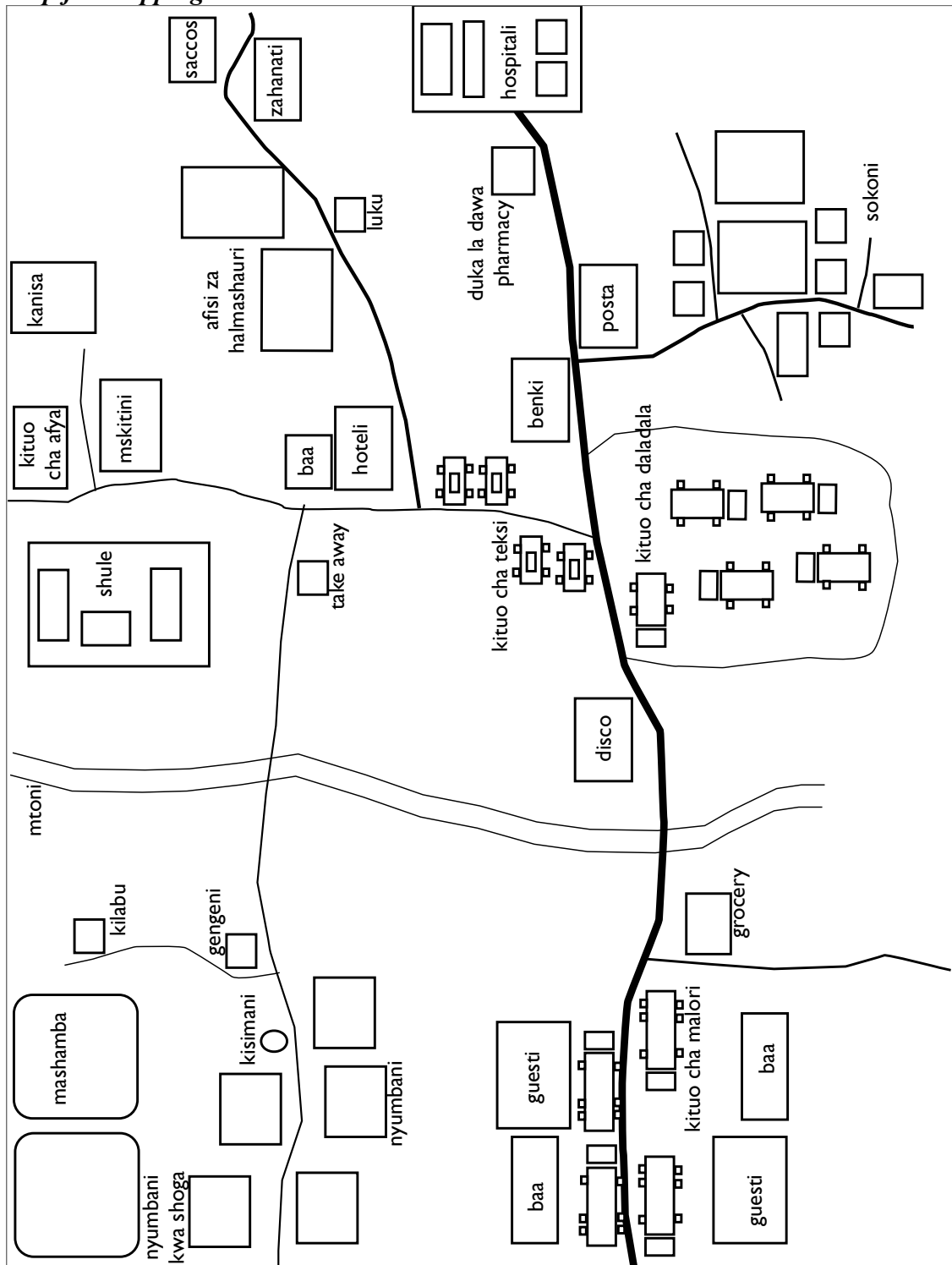
nguo za kitoto/children's clothing



intanet/Internet

\*Names were written here for the dissertation, but were not written on the pictures themselves during the interview.

# Map for Mapping Exercise



Monday, March 26, 12



Approved: June 15, 2011  
IRB No.: 00003616

Page 1 of 2

## JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

### INTERVIEW GUIDE

#### Focus group discussion guide for sex workers

**PI:** Dr. Caitlin Kennedy

**Study Title:** Strategic Assessment to Define a Comprehensive Response to HIV in Iringa, Tanzania

**IRB No.:** IRB00003616

**PI Version Number/Date:** Version #2\_May 24, 2011

---

#### INTRODUCTION

Thank you for agreeing to talk with us today.

The questions we have don't have any right or wrong answers. We are interested in any experiences, stories, and ideas you'd like to share. Please feel free to share your honest thoughts and opinions. We would like to ask you all to remember that what is said here today is confidential. Please don't share what happens here today with anyone outside this group.

Do you have any questions for me before we begin?

Great. Let's get started.

#### FOCUS GROUP DISCUSSION GUIDE

**First, let's go around the room and introduce ourselves. Please give us the name you would like to be called – this can be your real name, or it can be a nickname or another name that we can use just for today.**

**What does it mean to be a mother?**

- What does a mother do? What are her roles?
- What makes a good mother?

**What kinds of sexual partners are there?**

- Probe: mpenzi, mchumba, bwana, boyfriend, mme
- What are the differences between the types of partners?
- What makes a man one type of partner and not another?

**What is transactional sex? [elicit and use local term]**

- How is it different from sex work?

**What are all the words for women who exchange sex for money?**

- What does *umalaya* [and other words for sex work that they name] mean? Who is a *malaya*?
- What makes sex *sex work*?

Strategic Assessment to Define a Comprehensive Response to HIV in Iringa, Tanzania.  
IRB No.: IRB00003616 PI: Dr. Caitlin Kennedy V2 / May 24, 2011



Approved: June 15, 2011  
IRB No.: 00003616

Page 2 of 2

**What kind of man goes with a sex worker?**

- What kinds of things will they do together, beyond sex?

**What are the kinds of problems do SWs face?**

- Which of these are more and less serious?
- Which of these are more and less frequent?

**What are the particular challenges SWs face in also being mothers?**

**What does the community think of sex workers?**

- How do they view you and treat you?

**What kinds of health problems do SWs face?**

- Probe: HIV, STI, infertility, pregnancy, unwanted pregnancy, pregnancy by a client, violence/injury

**What is it like to go to a health clinic?**

- How are sex workers treated at clinics?
- Probe: differences between public, private, faith-based clinics

**Is there anything else you would like to tell me about the topics we have discussed today?**

That is the end of our discussion. Do you have any questions for us?



Approved: June 15, 2011  
IRB No.: 00003616

Page 1 of 2

**MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES (MUHAS)**

**JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH (JHSPH)**

**Focus Group Guide for Sex Working Mothers**

**US-based Principal Investigator:** Caitlin Kennedy (JHSPH)

**Tanzania-based Principal Investigator:** Jessie Mbwambo (MUHAS)

**Study Title:** Strategic Assessment to Define a Comprehensive Response to HIV in Iringa, Tanzania

**IRB No.:** IRB00003616

**PI Version Number/Date:** Version #1\_May 31, 2011

---

**UTANGULIZI**

Asante kwa kukubali kuongea na sisi leo.

Maswali tuliyonayo hayana jibu sahihi na lisilo sahihi. Tuna shauku kujua uzoefu, hadithi, na maoni yako kama ungependa kutushirikisha. Tafadhali, uwe huru kutushirikisha kwa uaminifu mawazo na maoni yako. Tungependa kuwaomba wote mkumbuke kuwa chochote kilichosemwa hapa leo ni siri. Tafadhali usimshirikishe mtu yeyote nje ya kikundi hiki mambo yaliyotokea hapa leo.

Je, una swali lolote kwangu kabla hatujaanza?

Vizuri. Tuanze. .

**MWONGOZO WA KIKUNDI CHA MAJADILIANO**

**Kwanza, Tujitambulishie kwa mzunguko ndani ya chumba hiki. Tafadhali tupe jina ambalo ungependa kuitwa – linaweza kuwa jina lako kabisa, jina la bandia au jina lolote lingine ambalo tunaweza kulitumia kwa leo tu.**

**Kuwa mama inamaanisha nini?**

- Je, mama hufanya nini? Ana wajibu gani?
- Kitu gani kinamfanya awe ni mama?

**Kuna aina gani za wenzi wa ngono?**

- Dadisi: mpenzi, mchumba, bwana, rafiki wa kiume, mme
- Kuna tofauti gani kati ya aina hizo za wenzi?
- Kitu gani kinamfanya mwanaume awe ni wa aina mojawapo kati ya wenzi hao na siyo aina nyingine?

**Biashara ya ngono ni nini? [shawishi aseme ukweli na tumia neno lililozoeleka mahali hapo]**

- Inatofautiana vipi na kazi ya ngono?

**Je, majina yote ya wanayopewa wanawake wanaobadili ngono kwa pesa ni yapi?**

Strategic Assessment to Define a Comprehensive Response to HIV in Iringa, Tanzania.  
IRB No.: IRB00003616 PI: Dr. Caitlin Kennedy V1 / May 31, 2011



Approved: June 15, 2011  
IRB No.: 00003616

Page 2 of 2

- Je, *umalaya* humaanisha nini? [ na majina mengine wanayowaita wafanya kazi ya ngono] humaanisha nini? Je, *malaya* ni nani?],
- Je, ni kitu gani kinachofanya ngono kuwa kazi ya *ngono*?

**Je, ni mwanaume wa aina gani anatembea na mfanyabishara ya ngono?**

- Ni vitu vya aina gani wanafanya pamoja zaidi ya kufanya ngono?

**Je, wafanya bishara ya ngono wanakutana na matatizo ya aina gani?**

- Ni yapi kati ya hayo ni matatizo makubwa na yapi ni madogo?
- Ni yapi kati ya hayo ni ya mara kwa mara na yapi siyo ya mara kwa mara?

**Wafanya biashara wa ngono ambao pia ni akina mama wanakumbana na changamoto gani hasa?**

**Jamii inawafikiriaje wafanya biashara ya ngono?**

- Wawafanyia nini na wawakuchukuliaje?

**Je. Wafanya biashara ya ngono wanapata matatizo gani ya kiafya?**

- Dadisi: VVU, magonjwa ya zinaa, utasa, mimba, mimba zisizotakiwa, mimba kwa wateja, kupigwa/kujeruhiwa.

**Inakuwaje wakienda kliniki?**

- Wafanya biashara ya ngono hufanyiwa nini katika kliniki?
- Dads: Tofauti kati ya kliniki za umma, kliniki binafsi, kliniki zenye misingi ya kiimani.

**Kuna jambo lingine lolote ungependa kuniambia kuhusu haya tuliyoyajadili leo?**

Asante , huu ndiyo mwisho wa majadiliano yetu. Una swali lolote ungependa kutuuliza?

### ***Revisions to FGD Guide for FSW***

-Tumia “wanaobadilishana ngono kwa pesa” badala ya “wanaofanya biashara wa ngono” [Use “they who exchange sex for money” instead of “they who do the sex trade”]

-At the beginning, do Mapping exercise as a group, let them discuss and argue

-After asking about *changomoto za akinamama* (challenges mothers face), ask also:

What challenges do mothers who also exchange sex for money have in watching their children? Probe: money for their needs, childcare while at work

What differences are there when mothers have small children versus bigger children (secondary school age)? What are the challenges for each age group? Probe: How is it when children learn that you exchange sex for money?

Before, we discussed what it means to be a mother. Now, what does it mean to be a good mother? A bad mother?





Approved: June 15, 2011  
IRB No.: 00003616

Page 1 of 2

## JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

### INTERVIEW GUIDE

#### Interview guide for Key Informant Interviews: NGO Workers

**PI:** Dr. Caitlin Kennedy

**Study Title:** Strategic Assessment to Define a Comprehensive Response to HIV in Iringa, Tanzania

**IRB No.:** IRB00003616

**PI Version Number/Date:** Version #1\_May 9, 2011

---

#### SOCIO-DEMOGRAPHICS

Gender:

Organization:

Role:

#### INTRODUCTION

Thank you for talking with me today.

We appreciate your time and appreciate you speaking with us about the work that you do. The information you provide today will remain completely confidential and will be helpful to help design or improve future comprehensive HIV programs in Iringa. Do you have any questions for me before we begin?

Great. Let's get started.

#### INTERVIEW GUIDE

1. Tell me a bit about your current role and the work of this organization.
2. What types of services or programs are provided by the organization you work with? How does your work relate to HIV prevention, treatment or care (directly or indirectly)?
3. What types of populations does your organization serve? What are the needs of the individuals that you serve?
4. How do you think services could be improved for this population? What are the gaps in services?
5. What, in your opinion, are the biggest problems in the community?
6. Does the organization provide any services geared toward sex workers or their clients? (if yes) what services?
7. What are the particular needs of the sex work population?

Strategic Assessment to Define a Comprehensive Response to HIV in Iringa, Tanzania.  
**IRB No.:** IRB00003616 **PI:** Dr. Caitlin Kennedy V1 / May 9, 2011



**Approved:** June 15, 2011  
**IRB No.:** 00003616

Page 2 of 2

8. How does transactional sex influence HIV risk and vulnerability?
9. What challenges does the organization face in trying to serve sex workers?
10. How do you define sex work/sex workers?
11. What challenges does the organization face in serving that population?
12. If money were no object, what would be your ideal intervention/study/implementation strategy?
13. Is there anything else you would like to tell me about the topics we have discussed today?

That is the end of our interview. Do you have any questions for me?

We appreciate your honest answers to our questions. Thank you for your time.



Approved: June 15, 2011  
IRB No.: 00003616

Page 1 of 2

**MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES (MUHAS)**

**JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH (JHSPH)**

## **INTERVIEW GUIDE**

### **Interview guide for Key Informant Interviews: NGO Workers**

**US-based Principal Investigator:** Caitlin Kennedy (JHSPH)

**Tanzania-based Principal Investigator:** Jessie Mbwambo (MUHAS)

**Study Title:** Strategic Assessment to Define a Comprehensive Response to HIV in Iringa, Tanzania

**IRB No.:** IRB00003616

**PI Version Number/Date:** Version #1\_May 31, 2011

---

### **DEMOGRAFIA ZA KIJAMII**

Jinsia:  
Shirika:  
Wadhifa:

### **UTANGULIZI**

Asante kwa kuzungumza na mimi leo.

Tunashukuru kwa muda wako na kwa kuongea nasi kuhusu kazi unayoifanya. Taarifa uliyoitoe leo itabaki kuwa siri kabisa na itasaidi kuunda au kuboresha Nyanja nyingi za programu za baadaye za VVU hapa Iringa. Je una maswali yoyote kwangu kabla hatujaanza?

Vizuri. Sasa tuanze.

### **MWONGOZO WA USAILI**

1. Niambie kidogo kuhusu wadhifa wako wa sasa na kazi yako katika shirika hili.
2. Shirika unalofanyia kazi hutoa aina gani za huduma au programu? Kazi yako inahusianaje na kinga, matibabu au matunzo ya VVU (moja kwa moja/siyo moja kwa moja)?
3. Shirika lenu linahudumia kundi gani la watu? Mahitaji ya watu mnaowahudumia ni yapi?
4. Unafikiria huduma kwa watu hawa inaweza kuboreshwa kwa namana gani? Kuna mapungufu gani katika huduma hizi?
5. Kwa mawazo yako, yapi ni matatizo makubwa zaidi katika jamii?
6. Je shirika linatoa huduma yoyote kwa wafanyabiashara ya ngono au wateja wao? (kama ndiyo)  
Huduma gani?

Strategic Assessment to Define a Comprehensive Response to HIV in Iringa, Tanzania.  
IRB No.: IRB00003616 PI: Dr. Caitlin Kennedy V1 / May 31, 2011



Approved: June 15, 2011  
IRB No.: 00003616

Page 2 of 2

7. Watu wafanyao biashara ya ngono wana mahitaji gani ya kila siku?
8. Biashara ya ngono inaathiri vipi uhatarifu na uwezekano wa kupata VVU?
9. Shirika linakabilana na changamoto gani katika kujaribu kuwasaidia wafanya biashara za ngono?
10. Unaelezeaje biashara ya ngono/mfanya biashara ya ngono?
11. Shirika linapata changamoto gani katika kuwahudumia kundi hili la watu?
12. Kama pesa ingekuwa siyo kikwazo, mbinu bora ya utekelezaji/utafiti/ utendaji wako ingekuwa ni ipi?
13. Kuna kitu chochote ungependa kuniambia kuhusu mada tuliyoijadili leo?

Huu ndiyo mwisho wa usaili huu. Una maswali yoyote kwangu?

Tunashukuru kwa majibu yako ya uaminifu. Asante kwa muda wako.



Approved: June 15, 2011  
IRB No.: 00003616

Page 1 of 2

**MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES (MUHAS)**

**JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH (JHSPH)**

## **INTERVIEW GUIDE**

### **Interview guide for Key Informant Interviews: Health Care Workers**

**US-based Principal Investigator:** Caitlin Kennedy (JHSPH)

**Tanzania-based Principal Investigator:** Jessie Mbwambo (MUHAS)

**Study Title:** Strategic Assessment to Define a Comprehensive Response to HIV in Iringa, Tanzania

**IRB No.:** IRB00003616

**PI Version Number/Date:** Version #1\_May 31, 2011

---

#### **Demografia za Kijamii:**

Jinsia:  
Shirika:  
Wadhifa:

#### **UTANGULIZI**

Asante kwa kuongea na sisi leo.

Tunashukuru kwa muda wako na kwa kuongea na sisi kuhusu kazi uifanyayo. Taarifa utakazotupatia leo zitakuwa ni siri kabisa na zitatusaidia sana katika kuandaa na kuboresha program za baadaye katika nyanja nyingi za VVU hapa Iringa. Je, una mwaswali yoyote kabla hatujaanza?

Vizuri: Tuanze.

#### **MWONGOZO WA USAILI:**

1. Nieleze kidogo kuhusu wadhifa wako wa sasa na kazi uifanyayo katika shirika hili?
2. Je, huduma gani au programua gani hutolewa na shirika unalofanya nalo kazi? Je. Kazi yako inahusianaje na kinga, matunzo na tiba ya VVU? (moja kwa moja au siyo moja kwa moja)
3. Shirika lako linawahudumia makundi gani ya watu? Je, watu binafsi mnaowahudumia wana mahitaji gani?
4. Je, huduma kwa watu hao zinaweza kuboreshwa vipi? Je, kuna mapungufu gani katika huduma hizo?
5. Je, kliniki hiyo inatoa huduma / inawahudumia watu gani? (Afya ya mama /mtoto, uzazi wa mpango, magonjwa ya zinaa, upimaji na matunzo ya VVU/UKIMWI nk.)

Strategic Assessment to Define a Comprehensive Response to HIV in Iringa, Tanzania.  
IRB No.: IRB00003616 PI: Dr. Caitlin Kennedy V1 / May 31, 2011



Approved: June 15, 2011  
IRB No.: 00003616

Page 2 of 2

6. Kwa mtazamo yako, matatizo makubwa zaidi katika jamii ni yapi? Je, katika kituo chako ?
  7. Mahitaji mahususi ya watu wanaofanya biashara ya ngono ni yapi?
  8. Je. kliniki inaelekeza huduma yoyote kwa wafanya biashara ya ngono au wateja wao? (kama ni ndiyo) huduma hizo ni zipi?
  9. Je, shirika linakumbana na changamoto gani katika kuwasaidia wafanya biashara ya ngono?
  10. Unaelezeaje kazi ya biashara ya ngono/wafanya biashara ya ngono?
  11. Je, shirika linakumbana na changamoto gani katika kuwasaidia kundi la watu hao?
  12. Wafanya biashara ya ngono wanaikukubali vipi elimu ya afya, ushahi nasaha wa afya, nk.? Kwa nini unafikiria hivyo/ sivyo?
  13. Tuchukulie kuwa mwanamke amekuja katika huduma hii ya matunzo, na ana ugojwa wa zinaa., Je, utafanyaje? Utamwambia nini? Nielekeze hatua kwa hatua utakavyofanya.
  14. Mambo gani mengine yanaendela katika mkoa huu ( kijamii, kisiasa, kiuchumi) ambayo yanaweza kuchangia ukweli kwamba mkoa huu una ueneaji mkubwa zaidi wa VVU?
  15. Sasa tuchukulie kuwa mwanamke anakuja kupata huduma ya matunzo, na ana mimba, Utafanya nini? Utamwambia nini? Nielezee hatua kwa hatua utakavyofanya.
  16. Sasa Tuchukulie kuwa amekuja mwanamke kupata huduma ya matunzo na anamwambia kwa sababu ya mimba kutoka. Je, utafanya nini? Utamwambia nini? Nielezee hatua kwa hatua utakavyofanya.
  17. Katika maelekezo hayo , ni yapi yatakuwa sawa na ni yapi yatakuwa tofauti kama utakuwa unajua kuwa mwanamke huyo ni mfanya biashara ya ngono?
  18. Kuna jambo lolote ungependa kuniambia kuhusu mada tulizozijadili leo?
- Huo ni mwisho wa usaili wetu. Una swali lolote kwangu?
- Tunashukuru sana kwa majibu yako ya uaminifu kwa maswali yetu. Asante kwa muda wako.

***Interview Guide Adapted for non-NGO/non-HCW Key Informants***

1. Tell me about what work you do and your position. Probe: Who is the boss or manager, what interactions are there between boss and employees?
2. What types of services do you and your workplace provide?
3. What types of customers do you serve?
4. Can you tell me about a typical workday? Probe: When do you come, what do you do, who works with you, what do they do, what do the customers do, how do you help clients meet women, how does the payment work?
5. If you could improve this work or workplace, how would you like to improve it?
6. What, in your opinion, are the biggest problems in the community? At the workplace?
7. How are women who exchange sex for money and their clients involved in this workplace?
8. What are the particular needs or challenges of women who exchange sex for money?
9. Do you know any women who exchange sex or money who have children? Can you tell me a couple stories about them?
10. What challenges do you face in interacting with women who exchange sex for money?
11. How do you define a “woman who exchanged sex for money”? How is that different from a “sex worker”? How is that different from a girl at school or university who has multiple partners who give her money and gifts?
12. What kinds of risks do women who exchange sex for money? Probe: violence, HIV, STI, pregnancy, abortion, infertility
13. Is there anything else you would like to tell me about the things we talked about today?

## Chapter 10. Bibliography

- Ahmed, A., Kaplan, M., Symington, A., & Kismodi, E. (2011). Criminalising consensual sexual behaviour in the context of HIV: Consequences, evidence, and leadership. *Global Public Health*, 6 Suppl 3, S357-69. doi:10.1080/17441692.2011.623136
- Akarro, R. R. J. (2009). Some factors associated with condom use among bar maids in Tanzania. *Journal of Biosocial Science*, 41(01), 125-137.
- Akujobi, R. (2011). Motherhood in African literature and culture. *CLCWeb: Comparative Literature and Culture*, 13.1.
- Alexander, K. A., Coleman, C. L., Deatricks, J. A., & Jemmott, L. S. (2012). Moving beyond safe sex to women-controlled safe sex: A concept analysis. *Journal of Advanced Nursing*, 68(8), 1858-69. doi:10.1111/j.1365-2648.2011.05881.x
- Alexander, P. (1998). Sex work and health: A question of safety in the workplace. *Journal of the American Medical Women's Association* (1972), 53(2), 77-82.
- Allen, D. R. (2002). *Managing motherhood, managing risk: Fertility and danger in West Central Tanzania*. Ann Arbor: University of Michigan Press.
- Altman, D. (2002). *Global sex*. Chicago: University of Chicago Press.
- Aluisio, A., Richardson, B. A., Bosire, R., John-Stewart, G., Mbori-Ngacha, D., & Farquhar, C. (2011). Male antenatal attendance and HIV testing are associated with decreased infant HIV infection and increased HIV-free survival. *Journal of Acquired Immune Deficiency Syndromes* (1999), 56(1), 76-82. doi:10.1097/QAI.0b013e3181fdb4c4
- Amadiume, I. (1987a). *Afrikan matriarchal foundations: The Igbo case*. London: Karnak House.
- Amadiume, I. (1987b). *Male daughters, female husbands: Gender and sex in an African society*. London; Atlantic Highlands, N.J.: Zed Books.
- Ao, T. T., Sam, N., Kiwelu, I., Mahal, A., Subramanian, S. V., Wyshak, G., & Kapiga, S. (2011). Risk factors of alcohol problem drinking among female bar/hotel workers in Moshi, Tanzania: A multi-level analysis. *AIDS and Behavior*, 15(2), 330-9. doi:10.1007/s10461-010-9849-y
- Ao, T. T., Sam, N. E., Masenga, E. J., Seage, G. R., & Kapiga, S. H. (2006). Human immunodeficiency virus type 1 among bar and hotel workers in northern



- Tanzania: The role of alcohol, sexual behavior, and herpes simplex virus type 2. *Sexually Transmitted Diseases*, 33(3), 163-9. doi:10.1097/01.olq.0000187204.57006.b3
- Arendell, T. (2000). Conceiving and investigating motherhood: The decade's scholarship. *Journal of Marriage and the Family*, 1192-1207.
- Auvinen, J., Kylma, J., & Suominen, T. (2013). Male involvement and prevention of mother-to-child transmission of HIV in sub-Saharan Africa: An integrative review. *Current HIV Research*, 11(2), 169-77.
- Baral, S., Beyrer, C., Muessig, K., Poteat, T., Wirtz, A. L., Decker, M. R., . . . Kerrigan, D. (2012). Burden of HIV among female sex workers in low-income and middle-income countries: A systematic review and meta-analysis. *The Lancet Infectious Diseases*, 12(7), 538-49. doi:10.1016/S1473-3099(12)70066-X
- Baral, S., Logie, C. H., Grosso, A., Wirtz, A. L., & Beyrer, C. (2013). Modified social ecological model: A tool to guide the assessment of the risks and risk contexts of HIV epidemics. *BMC Public Health*, 13(1), 482. doi:10.1186/1471-2458-13-482
- Barrington, C., Latkin, C., Sweat, M. D., Moreno, L., Ellen, J., & Kerrigan, D. (2009). Talking the talk, walking the walk: Social network norms, communication patterns, and condom use among the male partners of female sex workers in La Romana, Dominican Republic. *Social Science & Medicine* (1982), 68(11), 2037-44. doi:10.1016/j.socscimed.2009.03.009
- Basu, A., & Dutta, M. J. (2011). 'We are mothers first': Localocentric articulation of sex worker identity as a key in HIV/AIDS communication. *Women & Health*, 51(2), 106-23. doi:10.1080/03630242.2010.550992
- Bautista, C. T., Mejía, A., Leal, L., Ayala, C., Sanchez, J. L., & Montano, S. M. (2008). Prevalence of lifetime abortion and methods of contraception among female sex workers in Bogota. *Contraception*, 77(3), 209 - 213. doi: 10.1016/j.contraception.2007.11.013
- Beard, J., Biemba, G., Brooks, M. I., Costello, J., Ommerborn, M., Bresnahan, M., . . . Simon, J. L. (2010). Children of female sex workers and drug users: A review of vulnerability, resilience and family-centred models of care. *Journal of the International AIDS Society*, 13 Suppl 2, S6. doi:10.1186/1758-2652-13-S2-S6
- Betron, M. (2008). Gender-Based violence in Tanzania: An assessment of policies, services, and promising interventions. *Dar Es Salaam: USAID Health Policy Initiative*.

- Bletzer, K. V. (2005). Sex workers in agricultural areas: Their drugs, their children. *Culture, Health & Sexuality*, 7(6), 543-55. doi:10.1080/13691050500151271
- Brennan, D. (2007). Love work in a tourist town: Dominican sex workers and resort workers perform at love. In M. Padilla, J. Hirsch, M. Muzon-Laboy, R. E. Sember, & R. G. Parker (Eds.), *Love and globalization: Transformations of intimacy in the contemporary world*. Nashville, Tenn.: Vanderbilt University Press.
- Brusamento, S., Ghanotakis, E., Tudor Car, L., van-Velthoven, M. H., Majeed, A., & Car, J. (2012). Male involvement for increasing the effectiveness of prevention of mother-to-child HIV transmission (PMTCT) programmes. *Cochrane Database of Systematic Reviews (Online)*, 10, CD009468. doi:10.1002/14651858.CD009468.pub2
- Castañeda, X., Ortiz, V., Allen, B., García, C., & Hernández-Avila, M. (1996). Sex masks: The double life of female commercial sex workers in Mexico City. *Cult Med Psychiatry*, 20(2), 229-47.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London; Thousand Oaks, Calif.: Sage Publications.
- Chazan, N. (1999). *Politics and society in contemporary Africa*. Boulder, Colo.: Lynne Rienner Publishers.
- Chege, M. N., Kabiru, E. W., Mbithi, J. N., & Bwayo, J. J. (2002). Childcare practices of commercial sex workers. *East African Medical Journal*, 79(7), 382-9.
- Cheng, S. (2007). Romancing the club: Love dynamics between Filipina entertainers and GIs in US military camp towns in South Korea. In M. Padilla, J. Hirsch, M. Muzon-Laboy, R. E. Sember, & R. G. Parker (Eds.), *Love and globalization: Transformations of intimacy in the contemporary world*. Nashville, Tenn.: Vanderbilt University Press.
- Choi, S. Y., & Holroyd, E. (2007). The influence of power, poverty and agency in the negotiation of condom use for female sex workers in Mainland China. *Culture, Health & Sexuality*, 9(5), 489-503. doi:10.1080/13691050701220446
- Comaroff, J., & Comaroff, J. L. (1991). *Of revelation and revolution Vol 1 & 2*. Chicago: University of Chicago Press.
- Connell, R. W. (2002). *Gender*. Cambridge, UK: Polity; Malden, MA: Blackwell Publishers.

- Connell, R. W. (1987). *Gender and power: Society, the person and sexual politics*. Stanford University Press.
- Dalla, R. L. (2001). Et tú brutè? A qualitative analysis of streetwalking prostitutes' interpersonal support networks. *Journal of Family Issues*, 22(8), 1066-1085.
- Decker, M. R., McCauley, H. L., Phuengsamran, D., Janyam, S., & Silverman, J. G. (2011). Sex trafficking, sexual risk, sexually transmitted infection and reproductive health among female sex workers in Thailand. *J Epidemiol Community Health*, 65(4), 334-9. doi:10.1136/jech.2009.096834
- Decker, M. R., McCauley, H. L., Phuengsamran, D., Janyam, S., Seage, G. R., & Silverman, J. G. (2010). Violence victimisation, sexual risk and sexually transmitted infection symptoms among female sex workers in Thailand. *Sexually Transmitted Infections*, 86(3), 236-40. doi:10.1136/sti.2009.037846
- Decker, M. R., Yam, E. A., Wirtz, A. L., Baral, S. D., Peryshkina, A., Mogilnyi, V., & Beyrer, C. (2013). Induced abortion, contraceptive use, and dual protection among female sex workers in Moscow, Russia. *International Journal of Gynaecology and Obstetrics: The Official Organ of the International Federation of Gynaecology and Obstetrics*, 120(1), 27-31. doi:10.1016/j.ijgo.2012.07.026
- Delacoste, F., & Alexander, P. (1987). *Sex work. Writings by women in the sex industry*. San Francisco: Cleis Press.
- Delvaux, T., & Buvé, A. (2013). Hormonal contraception and HIV acquisition - what is the evidence? What are the policy and operational implications? *The European Journal of Contraception & Reproductive Health Care: The Official Journal of the European Society of Contraception*, 18(1), 15-26. doi:10.3109/13625187.2012.744819
- Elmore-Meegan, M., Conroy, R. M., & Agala, C. B. (2004). Sex workers in Kenya, numbers of clients and associated risks: An exploratory survey. *Reproductive Health Matters*, 12(23), 50-7.
- Feldblum, P. J., Nasution, M. D., Hoke, T. H., Van Damme, K., Turner, A. N., Gmach, R., . . . Behets, F. (2007). Pregnancy among sex workers participating in a condom intervention trial highlights the need for dual protection. *Contraception*, 76(2), 105-10. doi:10.1016/j.contraception.2007.04.009
- Fischer, G. (2013a). Recruitment and female labour in Tanzanian hospitality companies: An exploration. *Journal of Contemporary African Studies*, 31(1), 62-76.

- Fischer, G. (2013b). Tanzanian women's move into wage labour: Conceptualizing deference, sexuality and respectability as criteria for workplace suitability. *Gender, Work & Organization*.
- Fisher, J. C., Cook, P. A., & Kapiga, S. H. (2010). Alcohol use before sex and HIV risk: Situational characteristics of protected and unprotected encounters among high-risk African women. *Sexually Transmitted Diseases*, 37(9), 571-8. doi:10.1097/OLQ.0b013e3181dbafad
- Friese, S. (2012). *Qualitative data analysis with Atlas.Ti*. Thousand Oaks, CA: Sage Publications. (Original work published 2011)
- Gilovich, T. (1993). *How we know what isn't so: The fallibility of human reason in everyday life*. New York, N.Y.: Free Press. (Original work published 1991)
- Government of the United Republic of Tanzania. (1981). Tanzania penal code chapter 16 of the laws (revised) (principal legislation). Retrieved from [www.lrct.go.tz](http://www.lrct.go.tz)
- Gray, R. H., Li, X., Kigozi, G., Serwadda, D., Brahmbhatt, H., Wabwire-Mangen, F., . . . Wawer, M. J. (2005). Increased risk of incident HIV during pregnancy in Rakai, Uganda: A prospective study. *Lancet*, 366(9492), 1182-8. doi:10.1016/S0140-6736(05)67481-8
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? *Field Methods*, 18(1), 59-82. doi:10.1177/1525822X05279903
- Guyer, J. (1994). Lineal identities and lateral networks: The logic of polyandrous motherhood. In C. H. Bledsoe & G. Pison (Eds.), *Nuptiality in sub-Saharan Africa: Contemporary anthropological and demographic perspectives* (pp. 231-252). Oxford: Oxford University Press.
- Hampanda, K. M. (2013). The social dynamics of selling sex in Mombasa, Kenya: A qualitative study contextualizing high risk sexual behaviour. *African Journal of Reproductive Health: Vol. 17, No. 2, June 2013*, 141.
- Haram, L. (2003). 10. 'Prostitutes' or modern women? Negotiating respectability in northern Tanzania. In S. Arnfred (Ed.), *Re-thinking sexualities in Africa* (pp. 211-229). Uppsala: Nordic Africa Institute.
- Haram, L. (2005). "Eyes have no curtains": The moral economy of secrecy in managing love affairs among adolescents in northern Tanzania in the time of AIDS. *Africa Today*, 51(4), 57-73.

- Harcourt, C., & Donovan, B. (2005). The many faces of sex work. *Sexually Transmitted Infections*, 81(3), 201.
- Haws, R. A. (2009). *Women's experiences of stillbirth and other reproductive disruptions and their social consequences in southern Tanzania*. (Doctoral Dissertation). Retrieved from ProQuest Dissertations and Abstracts. (UMI No. 3356880)
- Hollos, M., & Larsen, U. (2008). Motherhood in sub-Saharan Africa: The social consequences of infertility in an urban population in northern Tanzania. *Culture, Health & Sexuality*, 10(2), 159-73. doi:10.1080/13691050701656789
- Human Rights Watch, & WASO. (2013). "Treat us like human beings": Discrimination against sex workers, sexual and gender minorities, and people who use drugs in Tanzania. *Human Rights Watch*.
- Iliffe, J. (1979). *A modern history of Tanganyika. African Studies Series, [25]*. Cambridge; New York: Cambridge University Press.
- Ivanoff, S. D., & Hultberg, J. (2006). Understanding the multiple realities of everyday life: Basic assumptions in focus-group methodology. *Scand J Occup Ther*, 13(2), 125-32.
- Iwelunmor, J., Zungu, N., & Airhihenbuwa, C. O. (2010). Rethinking HIV/AIDS disclosure among women within the context of motherhood in South Africa. *American Journal of Public Health*, 100(8), 1393.
- Jana, S., Basu, I., Rotheram-Borus, M. J., & Newman, P. A. (2004). The Sonagachi project: A sustainable community intervention program. *AIDS Education and Prevention*, 16(5), 405-14.
- Kapiga, S. H., Sam, N. E., Shao, J. F., Masenga, E. J., Renjifo, B., Kiwelu, I. E., . . . Essex, M. (2003). Herpes simplex virus type 2 infection among bar and hotel workers in northern Tanzania: Prevalence and risk factors. *Sexually Transmitted Diseases*, 30(3), 187-92.
- Kapiga, S. H., Sam, N. E., Shao, J. F., Renjifo, B., Masenga, E. J., Kiwelu, I. E., . . . Essex, M. (2002). HIV-1 epidemic among female bar and hotel workers in northern Tanzania: Risk factors and opportunities for prevention. *Journal of Acquired Immune Deficiency Syndromes (1999)*, 29(4), 409-17.
- Katapa, R. S. (2006). A comparison of female- and male-headed households in Tanzania and poverty implications. *Journal of Biosocial Science*, 38(3), 327-39. doi:10.1017/S0021932005007169

- Kerrigan, D., Ellen, J. M., Moreno, L., Rosario, S., Katz, J., Celentano, D. D., & Sweat, M. (2003). Environmental-structural factors significantly associated with consistent condom use among female sex workers in the Dominican Republic. *AIDS (London, England)*, 17(3), 415-23.
- Kerrigan, D., Moreno, L., Rosario, S., Gomez, B., Jerez, H., Barrington, C., . . . Sweat, M. (2006). Environmental-structural interventions to reduce HIV/STI risk among female sex workers in the Dominican Republic. *American Journal of Public Health*, 96(1), 120-5.
- Kerrigan, D. L., Fonner, V. A., Stromdahl, S., & Kennedy, C. E. (2013). Community empowerment among female sex workers is an effective HIV prevention intervention: A systematic review of the peer-reviewed evidence from low-and middle-income countries. *AIDS and Behavior*, 1-15.
- Kerrigan, D. L., Moreno, L., Rosario, S., & Sweat, M. (2001). Adapting the Thai 100% condom programme: Developing a culturally appropriate model for the Dominican Republic. *Culture, Health, and Sexuality*, 3(2), 221-240.
- Kiaga, &. (2007). Blaming the Other Woman: Rural Housegirls and Urban Employers on Identity, Labor and Migration in Tanzania. (Doctoral Dissertation). Retrieved from ProQuest Dissertations and Abstracts. (UMI No. 3280716).
- Kielmann, K. (1998). Barren ground: Contesting identities of infertile women in Pemba, Tanzania. In M. Lock & P. Kaufert (Eds.), *Pragmatic women and body politics* (pp. 127-163). Cambridge: Cambridge Univ Press.
- Leclerc-Madlala, S. (2003). Transactional sex and the pursuit of modernity. *Social Dynamics*, 29(2), 213-233.
- Lieve, V. d., Shafer, L. A., Mayanja, B. N., Whitworth, J. A., & Grosskurth, H. (2007). Effect of pregnancy on HIV disease progression and survival among women in rural Uganda. *Tropical Medicine & International Health: TM & IH*, 12(8), 920-8. doi:10.1111/j.1365-3156.2007.001873.x
- Maduna-Butshe, A. C. (1997). Women sex workers and the HIV pandemic: Stigma and blame in context. *SafAIDS News*, 5(1), 8-11.
- Maganja, R. K., Maman, S., Groves, A., & Mbwapbo, J. K. (2007). Skinning the goat and pulling the load: Transactional sex among youth in Dar es Salaam, Tanzania. *AIDS Care*, 19(8), 974-81. doi:10.1080/09540120701294286

- Maharaj, Z. (1995). A social theory of gender: Connell's "gender and power." *Feminist Review*, (49), 50-65.
- Marsh, D. R., Schroeder, D. G., Dearden, K. A., Sternin, J., & Sternin, M. (2004). The power of positive deviance. *BMJ (Clinical Research Ed.)*, 329(7475), 1177-9. doi:10.1136/bmj.329.7475.1177
- Mbonye, M., Nalukenge, W., Nakamanya, S., Nalusiba, B., King, R., Vandepitte, J., & Seeley, J. (2012). Gender inequity in the lives of women involved in sex work in Kampala, Uganda. *Journal of the International AIDS Society*, 15 Suppl 1, 1-9.
- McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education & Behavior*, 15(4), 351.
- McMahon, E. M. (2005). Becoming Pembani: Identity, social welfare and community during the protectorate period. (Doctoral Dissertation). Retrieved from ProQuest Dissertations and Abstracts. (UMI No. 3183467).
- Metzenrath, S. (1998). In touch with the needs of sex workers. *Research for Sex Work*, 11, 1-3.
- Morgan, D. L. (1997). *Qualitative Research Methods Series: Vol. 16. Focus groups as qualitative research* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Mugo, N. R., Heffron, R., Donnell, D., Wald, A., Were, E. O., Rees, H., . . . Partners in Prevention HSV/HIV Transmission Study Team. (2011). Increased risk of HIV-1 transmission in pregnancy: A prospective study among African HIV -1-serodiscordant couples. *AIDS (London, England)*, 25(15), 1887-95. doi:10.1097/QAD.0b013e32834a9338
- Murray, L., & MODEMU. (2002). *Laughing on the outside, crying on the inside* [Rien Mis Labios Lloro Mi Alma] (2 ed.). Santo Domingo, Dominican Republic: Movimiento de Mujeres Unidas.
- Murray, L., Moreno, L., Rosario, S., Ellen, J., Sweat, M., & Kerrigan, D. (2007). The role of relationship intimacy in consistent condom use among female sex workers and their regular paying partners in the Dominican Republic. *AIDS Behavior*, 11(3), 463-70.
- Murray, L. R., Lippman, S. A., Donini, A. A., & Kerrigan, D. (2010). 'She's a professional like anyone else': Social identity among Brazilian sex workers. *Culture, Health & Sexuality*, 12(3), 293-306. doi:10.1080/13691050903450122

- Nagle, J. (2010). *Whores and other feminists*. New York: Routledge. (Original work published in 1997).
- National AIDS Control Program. (2005). National guidelines for the clinical management of HIV and AIDS. Ministry of Health, the United Republic of Tanzania.
- National AIDS Control Programme. (2012). HIV behavioral and biological surveillance survey among female sex workers in Dar es Salaam 2010. Ministry of Health, the United Republic of Tanzania.
- National Bureau of Statistics. (2011). Tanzania Demographic & Health Survey 2010. Dar es Salaam: National Bureau of Statistics.
- National Bureau of Statistics, & Ministry of Finance. (2013). *2012 population and housing census*. Dar es Salaam: Government of Tanzania. Retrieved from <http://www.nbs.go.tz/sensa/new.html>
- Ngugi, E. N., Roth, E., Mastin, T., Nderitu, M. G., & Yasmin, S. (2012). Female sex workers in Africa: Epidemiology overview, data gaps, ways forward. *SAHARA J: Journal of Social Aspects of HIV/AIDS Research Alliance / SAHARA, Human Sciences Research Council*, 9(3), 148-53. doi:10.1080/17290376.2012.743825
- Nkya, W. M., Gillespie, S. H., Howlett, W., Elford, J., Nyamuryekunge, C., Assenga, C., & Nyombi, B. (1991). Sexually transmitted diseases in prostitutes in Moshi and Arusha, northern Tanzania. *International Journal of STD & AIDS*, 2(6), 432-5.
- Nnko, S., Boerma, J. T., Urassa, M., Mwaluko, G., & Zaba, B. (2004). Secretive females or swaggering males? An assessment of the quality of sexual partnership reporting in rural Tanzania. *Social Science & Medicine* (1982), 59(2), 299-310. doi:10.1016/j.socscimed.2003.10.031
- Nzegwu, N. (2006). *Family matters: Feminist concepts in African philosophy of culture*. Albany: State University of New York Press.
- O'Malley, G. E. (2002). Marriage and morality: Negotiating gender and respect in Zanzibar Town. (Doctoral Dissertation) Retrieved from ProQuest Dissertation and Abstracts. (UMI No. 9983530).
- Outwater, Nkya, Lyamuya, Lwihula, Green, Hogle, . . . Dallabetta. (2001). Health care seeking behavior for sexually transmitted diseases among commercial sex workers in Morogoro, Tanzania. *Culture, Health and Sexuality*, 3(1), 19-33.
- Oyewumi, O. (2003). Abiyamo: Theorizing African motherhood. *JENda: A Journal of Culture and African Women Studies*, (4).



- Padilla, M., Hirsch, J., Munoz-Laboy, M., Sember, R.E., Parker, R.G. (2007). *Love and globalization: Transformations of intimacy in the contemporary world*. Nashville, Tenn.: Vanderbilt University Press.
- Parker, R., & Easton, D. (1998). Sexuality, culture, and political economy: Recent developments in anthropological and cross-cultural sex research. *Annual Review of Sex Research*, 9, 1.
- Parker, R. G., Barbosa, R. M., & Aggleton, P. (2000). *Framing the sexual subject: The politics of gender, sexuality, and power*. Berkeley: University of California Press.
- Pheterson, G. (1989). *A vindication of the rights of whores*. Seattle, WA: Seal press.
- Pizzo, D. (2007). To devour the land of Mkwawa: Colonial violence and the German-Hehe war in East Africa c. 1884-1914. (Doctoral Dissertation). Retrieved from ProQuest Dissertations and Abstracts. (UMI No. 3304421).
- Preston-Whyte, E., Varga, C., Oosthuizen, H., Roberts, R., & Blose, F. (2000). Survival sex and HIV/AIDS in an African city. In R. Parker, R. M. Barbosa, & P. Aggleton (Eds.), *Framing the sexual subject: The politics of gender, sexuality, and power* (pp. 165-190). Berkeley: University of California Press.
- Prüss-Ustün, A., Wolf, J., Driscoll, T., Degenhardt, L., Neira, M., & Calleja, J. M. (2013). HIV due to female sex work: Regional and global estimates. *PloS One*, 8(5), e63476. doi:10.1371/journal.pone.0063476
- Reed, E., Silverman, J. G., Stein, B., Erausquin, J. T., Biradavolu, M., Rosenberg, A., & Blankenship, K. M. (2012). Motherhood and HIV risk among female sex workers in Andhra Pradesh, India: The need to consider women's life contexts. *AIDS and Behavior*, 1-8.
- Renzaho, A., & Pallotta-Chiarolli, M. (2009). Commercial sex work, survival sex, sexual violence and HIV/AIDS prevention in Arumeru district, Arusha Region of Tanzania. *Open Tropical Medicine Journal*, 2, 27-38.
- Riedner, G., Hoffmann, O., Rusizoka, M., Mmbando, D., Maboko, L., Grosskurth, H., . . . Hoelscher, M. (2006). Decline in sexually transmitted infection prevalence and HIV incidence in female barworkers attending prevention and care services in Mbeya Region, Tanzania. *AIDS*, 20(4), 609-15. doi:10.1097/01.aids.0000210616.90954.47
- Riedner, G., Rusizoka, M., Hoffmann, O., Nichombe, F., Lyamuya, E., Mmbando, D., . . . Grosskurth, H. (2003). Baseline survey of sexually transmitted infections in a

- cohort of female bar workers in Mbeya Region, Tanzania. *Sexually Transmitted Infections*, 79(5), 382-7.
- Rivers-Moore, M. (2010). But the kids are okay: Motherhood, consumption and sex work in neo-liberal Latin America. *Br J Sociol*, 61(4), 716-36. doi:10.1111/j.1468-4446.2010.01338.x
- Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing and Health*, 18, 179-183.
- Scambler, G., & Paoli, F. (2008). Health work, female sex workers and HIV/AIDS: Global and local dimensions of stigma and deviance as barriers to effective interventions. *Social Science & Medicine* (1982), 66(8), 1848-62. doi:10.1016/j.socscimed.2008.01.002
- Scheibe, A., Drame, F. M., & Shannon, K. (2012). HIV prevention among female sex workers in Africa. *SAHARA J: Journal of Social Aspects of HIV/AIDS Research Alliance / SAHARA, Human Sciences Research Council*, 9(3), 167-72. doi:10.1080/17290376.2012.743809
- Schoepf, B. G. (1992). Women at risk: Case studies from Zaire. *The Time of AIDS: Social Analysis, Theory and Method*, 259-286.
- Scorgie, F., Chersich, M. F., Ntaganira, I., Gerbase, A., Lule, F., & Lo, Y. R. (2012). Socio-demographic characteristics and behavioral risk factors of female sex workers in sub-Saharan Africa: A systematic review. *AIDS and Behavior*. 16(4), 920-933. doi:10.1007/s10461-011-9985-z
- Scorgie, F., Nakato, D., Harper, E., Richter, M., Maseko, S., Nare, P., . . . Chersich, M. (2013). 'We are despised in the hospitals': Sex workers' experiences of accessing health care in four African countries. *Culture, Health & Sexuality*, 15(4), 450-65. doi:10.1080/13691058.2012.763187
- Setel, P. (1999). *A plague of paradoxes: AIDS, culture, and demography in northern Tanzania*. Chicago: University of Chicago Press.
- Shagi, C., Vallely, A., Kasindi, S., Chiduo, B., Desmond, N., Soteli, S., . . . Microbicides Development Programme. (2008). A model for community representation and participation in HIV prevention trials among women who engage in transactional sex in Africa. *AIDS Care*, 20(9), 1039-49. doi:10.1080/09540120701842803
- Shaver, F. M. (2005). Sex work research: Methodological and ethical challenges. *J Interpers Violence*, 20(3), 296-319. doi:10.1177/0886260504274340

- Shillington, K. (2005). *History of Africa* (2nd Revised ed.). New York: St. Martin's Press. (Original work published 1989).
- Sloss, C. M., & Harper, G. W. (2004). When street sex workers are mothers. *Arch Sex Behav*, 33(4), 329-41. doi:10.1023/B:ASEB.0000028886.95568.2b
- Sudarkasa, N. (2004). Conceptions of motherhood in nuclear and extended families, with special reference to comparative studies involving African societies. *JENdA: A Journal of Culture and African Women Studies*, (5).
- Sweat, M. D., & Denison, J. A. (1995). Reducing HIV incidence in developing countries with structural and environmental interventions. *AIDS (London, England)*, 9 Suppl A, S251-7.
- Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), & ICF International. (2013). Tanzania HIV/AIDS and malaria indicator survey 2011-12.
- Tanzania Ministry of Health and Social Welfare. (2012). Tanzania national guidelines for comprehensive care of PMTCT services, 3rd edition. Retrieved from <http://pmtct.or.tz/resource/tanzania-national-guidelines-for-comprehensive-care-of-pmtct-services-3rd-edition/>
- Tanzania Non-governmental Organizations' Shadow Report to CEDAW: The Implementation of the Convention on the Elimination of All Forms of Discrimination Against Women. (2008). Presented at United Nations Convention on the Elimination of All Forms of Discrimination Against Women, 2008.
- Tassiopoulos, K. K., Seage, G., Sam, N., Kiwelu, I., Shao, J., Ao, T. T., . . . Kapiga, S. (2007). Predictors of herpes simplex virus type 2 prevalence and incidence among bar and hotel workers in Moshi, Tanzania. *The Journal of Infectious Diseases*, 195(4), 493-501. doi:10.1086/510537
- Todd, C. S., Alibayeva, G., Sanchez, J. L., Bautista, C. T., Carr, J. K., & Earhart, K. C. (2006). Utilization of contraception and abortion and its relationship to HIV infection among female sex workers in Tashkent. *Contraception*, 74(4), 318 - 323. doi: 10.1016/j.contraception.2006.04.006
- Todd, C. S., Nasir, A., Raza Stanekzai, M., Scott, P. T., Strathdee, S. A., Botros, B. A., & Tjaden, J. (2010). Contraceptive utilization and pregnancy termination among female sex workers in Afghanistan. *Journal of Women's Health (2002)*, 19(11), 2057-62. doi:10.1089/jwh.2010.1947

- Tomori, C., Francisco, L. V., Kennedy, C. E., Kajula-Maonga, L., Likindikoki, S., Babalola, S. O., . . . Kerrigan, D. L. (2013). The changing cultural and economic dynamics of polygyny and concurrent sexual partnerships in Iringa, Tanzania. *Global Public Health*, 8(7), 857-70. doi:10.1080/17441692.2013.815249
- Tsuruta, T. (2006). African imaginations of moral economy: Notes on indigenous economic concepts and practices in Tanzania. *African Studies Quarterly*, 9(1-2), 104-121.
- UNICEF. (2012). Preventing mother-to-child transmission (PMTCT) of HIV. Geneva: UNICEF. Retrieved from [http://www.unicef.org/aids/index\\_preventionyoung.html](http://www.unicef.org/aids/index_preventionyoung.html)
- Wahab, & Sloan. (2004). Ethical dilemmas in sex work research. *Research for Sex Work*, 3-6.
- Walker, C. (1995). Conceptualising motherhood in twentieth century South Africa. *Journal of Southern African Studies*, 21(3), 417-437. doi:10.2307/2637252
- Wamoyi, J., Fenwick, A., Urassa, M., Zaba, B., & Stones, W. (2011). "Women's bodies are shops": Beliefs about transactional sex and implications for understanding gender power and HIV prevention in Tanzania. *Arch Sex Behav*, 40(1), 5-15. doi:10.1007/s10508-010-9646-8
- Wamoyi, J., Wight, D., Plummer, M., Mshana, G. H., & Ross, D. (2010). Transactional sex amongst young people in rural northern Tanzania: An ethnography of young women's motivations and negotiation. *Reproductive Health*, 7(1), 2. doi:10.1186/1742-4755-7-2
- Watson-Jones, D., Baisley, K., Weiss, H. A., Tanton, C., Chagalucha, J., Everett, D., . . . Hayes, R. (2009). Risk factors for HIV incidence in women participating in an HSV suppressive treatment trial in Tanzania. *AIDS*, 23(3), 415-22. doi:10.1097/QAD.0b013e32831ef523
- Watson-Jones, D., Weiss, H. A., Rusizoka, M., Baisley, K., Mugeye, K., Chagalucha, J., . . . Hayes, R. J. (2007). Risk factors for herpes simplex virus type 2 and HIV among women at high risk in northwestern Tanzania: Preparing for an HSV-2 intervention trial. *Journal of Acquired Immune Deficiency Syndromes (1999)*, 46(5), 631-42. doi:10.1097/QAI.0b013e31815b2d9c
- Wayal, S., Cowan, F., Warner, P., Copas, A., Mabey, D., & Shahmanesh, M. (2011). Contraceptive practices, sexual and reproductive health needs of HIV-positive and negative female sex workers in Goa, India. *Sexually Transmitted Infections*, 87(1), 58-64. doi:10.1136/sti.2010.043158

- Weine, S., Golobof, A., Bahromov, M., Kashuba, A., Kalandarov, T., Jonbekov, J., & Loue, S. (2013). Female migrant sex workers in Moscow: Gender and power factors and HIV risk. *Women & Health*, 53(1), 56-73. doi:10.1080/03630242.2012.739271
- Willis, J. (2002). *Potent brews: A social history of alcohol in East Africa, 1850-1999*. London: British Institute in Eastern Africa in association with James Currey; Athens: Ohio University Press.
- Wingood, G. M., Scd, & DiClemente, R. J. (2000). Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. *Health Education & Behavior: The Official Publication of the Society for Public Health Education*, 27(5), 539-65.
- World Health Organization. (2006). Addressing violence against women in HIV testing and counseling: A meeting report, Geneva, 16--18 January 2006. *World Health Organization*.
- World Health Organization. (2010). Medical eligibility criteria for contraceptive use, 4th edition. *World Health Organization*. Retrieved from [www.who.int/reproductivehealth](http://www.who.int/reproductivehealth)
- World Health Organization. (2012). Guidance on couples HIV testing and counseling including antiretroviral therapy for treatment and prevention in serodiscordant couples: Recommendations for a public health approach. Retrieved from <http://www.who.int/hiv/pub/guidelines/9789241501972/en/index.html>
- World Health Organization, UNICEF, & UNAIDS. (2013). *Global Update on HIV Treatment 2013: Results, Impact and Opportunities*.
- Yam, E. A., Mnisi, Z., Sithole, B., Kennedy, C., Kerrigan, D. L., Tsui, A. O., & Baral, S. (2013). Association between condom use and use of other contraceptive methods among female sex workers in Swaziland: A relationship-level analysis of condom and contraceptive use. *Sexually Transmitted Diseases*, 40(5), 406-12. doi:10.1097/OLQ.0b013e318283c16d
- Zalwango, F., Eriksson, L., Seeley, J., Nakamanya, S., Vandepitte, J., & Grosskurth, H. (2010). Parenting and money making: Sex work and women's choices in urban Uganda. *Wagadu*, 8(Fall).

## Chapter 11. Curriculum Vita

### Sarah W. Beckham

PO Box 1441 • Iringa, Tanzania

Phone: +255 756 975 983 TZ / +1-443-990-1407 US • E-Mail: sbeckham@jhsphe.edu

Born August 31, 1979, Auburn, Washington, USA

#### EDUCATION

- Dec 2013     **Doctor of Philosophy (PhD)** in International Health  
Johns Hopkins Bloomberg School of Public Health, Baltimore, MD  
**Concentration:** Social and Behavioral Interventions  
**Dissertation:** “Like Any Other Woman”? Pregnancy, Motherhood and HIV among Sex Workers in Southern Tanzania  
**Research Interests:** HIV/AIDS interventions among key populations and in resource-limited settings; sexual and reproductive health; maternal health; multi-level approaches to designing, conducting, and evaluating health interventions; mixed-methods research
- May 2009     **Master of Public Health (MPH)**  
Yale University School of Public Health, New Haven, CT  
**Concentration:** Social and Behavioral Sciences  
**Master of Arts (MA)** in African Studies, *with Honors*  
Yale University MacMillan Center for International and Area Studies  
**MPH/MA Thesis:** Adherence to Antiretroviral Therapies in Resource-Poor Settings: A Mixed-Methods Case Study in Rural Tanzania
- Dec 2001     **Bachelor of Arts (BA)**, *magna cum laude*  
Brigham Young University, Provo, UT  
**Majors:** International Studies, History  
**Minor:** African Studies

#### PROFESSIONAL EXPERIENCE

- 2011-present     **Research Assistant**  
USAID-funded Project SEARCH—Research to Prevention (R2P), Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD  
**Director:** Deanna Kerrigan, PhD, Johns Hopkins Bloomberg School of Public Health  
**Roles:** Provide in-country support for the Strategic Assessment to Define a Comprehensive Response to HIV in Iringa, Tanzania and Evaluating a Combination of Prevention Interventions to Reduce HIV Incidence in the Iringa Region of Tanzania. Represent JHU to NGOs, government officials, and clinics, and manage logistics in Tanzania. Train data collectors in

qualitative research, HIV/AIDS prevention & treatment, and working with vulnerable populations. Supervise data collectors, meet regularly, and provide feedback. Manage textual data, write summaries, and report to JHU team, with focus on key populations. Assist in designing survey. Prepare abstracts and manuscripts for conferences and publication in peer-reviewed literature. Prepare literature reviews, annotated bibliographies, and reports from scholarly, programmatic, and technical literature on HIV and AIDS in Tanzania.

2012-2013

**Doctoral Dissertation Research Fellow**

*Data collection, analysis, and writing of doctoral dissertation*

**Grants:** Fulbright-Hays Doctoral Dissertation Research Abroad Award; Johns Hopkins Doctoral Dissertation Research Abroad Award; R2P Doctoral Dissertation Support; Georgeda Buchbinder Memorial Fund; Marjorie F. and Joseph I. Berman Family Award; Center for Qualitative Studies in Health & Medicine Dissertation Enhancement Award

**PIs:** Sarah Beckham, Deanna Kerrigan, PhD (advisor), Peter Winch, MD, MPH (co-advisor), Chris Beyrer, MD, MPH (committee member)

Conducted research for dissertation. Hired, trained, and oversaw interviewer and transcriptionists. Designed survey with psychosocial scales & indexes. Coded and analyzed in-depth, semi-structured, and life history interviews in Kiswahili. Presented findings at national and international conferences.

2010

**Research Assistant**

*Afya ya Uzazi, Zanzibar, Tanzania*

*Research on the unmet need for contraception and the consequences of unintended pregnancy*

**Grant:** Ellertson Postdoctoral Research Funds, Ibis Reproductive Health, and the Society for Family Planning, granted to Alison Norris

**PI:** Alison Norris, MD, PhD, and Michelle Hindin, PhD, Johns Hopkins University

**Roles:** Collaborated in the design, collection, analysis, and publication of mixed-method research. Assisted with in-country research, including hiring, training, and supervising research assistants; budgeting; securing research sites and local collaborators, coordinating multi-method data collection. Assisted in design of survey and semi-structured instruments and data management. Conducted in-depth interviews in Kiswahili with post-abortion patients.

2010

**Student Investigator**

*Development of a Proposal for a Doctoral Thesis on Malaria Control, Eradication, and Resurgence in Zanzibar, Tanzania*

**Grant:** The Robert D. and Helen S. Wright Fellowship in International Health through the Johns Hopkins School of Public Health

- PI:** Sarah Beckham, MPH/MA and Peter Winch, MD, MPH, Johns Hopkins University  
**Roles:** Identified and interviewed key players from past and current malaria control programs. Established contacts, secured permissions, and searched the Zanzibar National Archives for relevant twentieth-century documents.
- 2008      **Student Investigator**  
 Chake Chake District Hospital, Pemba Island, Zanzibar, Tanzania  
*Master's thesis research on adherence to antiretroviral drugs among people living with HIV/AIDS*  
**Grants:** The Curtis D. Heaney Fellowship for HIV/AIDS Research and the E. Richard Weinerman Fellowship through the Yale School of Public Health  
**PI:** Sarah Beckham, and Kaveh Khoshnood, DrPH, Yale University  
**Roles:** Independently designed, conducted, and analyzed research using mixed-methods. Obtained ethical approval through university and local institutional review boards. In Kiswahili, conducted focus group discussions, surveys, and in-depth interviews with patients, health care personnel, and key informants.
- 2004-2007      **Research Assistant**  
 Center for Interdisciplinary Research on AIDS, Yale University, New Haven, CT  
**Roles:** Prepared multiple literature reviews, annotated bibliographies, and reports on drug use and sex work. Transcribed and summarized life history and semi-structured interviews. Collaborated in design and analysis of mixed-methods research to monitor and evaluate Gates-funded community mobilization HIV/AIDS interventions for sex workers in India.
- 2006- 2007      **Consultant**  
 Connecticut AIDS Resource Coalition, Hartford, CT  
**Roles:** Volunteered time and expertise to research impact of policy change affecting needle-exchange outreach services in Connecticut. Interviewed needle-exchange staff and customers. Successfully obtained IRB approval from university and state boards. Wrote and presented report on findings in the context of comparative domestic and foreign policy.
- 2006      **Student Investigator**  
 Chake Chake District Hospital, Pemba Island, Zanzibar, Tanzania  
*Research on access and barriers to treatments for maternal anemia*  
**Grants:** Lindsay Fellowship for Research in Africa through the Yale MacMillan Center for International and Area Studies; and grants through Cornell University Department of Human Ecology, granted to Sera young  
**PI:** Sera Young, PhD, Cornell University  
**Roles:** Collaborated with investigators from US and Zanzibar to design, conduct, analyze, and publish research. Hired and supervised two research



assistants. In Kiswahili, conducted focus group discussions, surveys, and interviews with patients, health care personnel, and pharmacy staff.

- 1999-2003     **Student Investigator & Facilitator**  
International Study Programs, Brigham Young University, Provo, UT, & Tanzania  
*Field studies program to support undergraduate students in research abroad*  
**Grants:** University Scholarships and International Studies Program Scholarship  
**PI:** Sarah Beckham  
**Roles:** Independently conducted two research projects on the medical anthropology of malaria in 1999 and 2001. Conducted research on the local practice of Islam. Processed applications, interviewed, and prepared students for program. Mentored group of five students in their field studies experience. Individually contracted with professors to take classes while in the field.

## **RESEARCH FELLOWSHIPS & AWARDS**

- Fulbright-Hays Doctoral Dissertation Research Abroad Fellowship, 2013  
U.S. Department of Education  
*Financial support for dissertation research abroad, \$29,656*
- Dissertation Enhancement Award, 2012-13  
Center for Qualitative Studies in Health & Medicine, Johns Hopkins Bloomberg School of Public Health  
*Financial support for dissertation research and writing*
- Georgeda Buchbinder Memorial Fund in International Health, 2012  
Johns Hopkins Bloomberg School of Public Health  
*Financial support for summer research abroad*
- Marjorie F. & Joseph I. Berman Family Award, 2011, 2012  
Johns Hopkins Bloomberg School of Public Health  
*School-wide endowed student support award*
- Johns Hopkins Doctoral Dissertation Research Abroad Award, 2012  
Johns Hopkins University  
*Financial support for dissertation research abroad, \$30,000*
- R2P Doctoral Dissertation Award, 2011-12  
USAID-funded Research to Prevention (R2P), Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health  
*Financial support for dissertation research*
- The Robert D. and Helen S. Wright Fellowship in International Health, 2010  
Johns Hopkins Bloomberg School of Public Health  
*Financial support for summer research abroad*

Curtis D. Heaney Fellowship for HIV/AIDS Research, 2007  
Yale University School of Public Health  
*Financial support for summer research abroad*

E. Richard Weinerman Fellowship, 2007  
Yale University School of Public Health  
*Financial support for summer research abroad*

Lindsay Fellowship for Research in Africa, 2006  
Yale University MacMillan Center for International and Area Studies  
*Financial support for summer research abroad*

## **SCHOLARSHIPS**

International Health Departmental Scholarship, 2009-13  
Johns Hopkins Bloomberg School of Public Health  
*Full tuition support for four years plus stipend for two years*

Foreign Language and Area Studies Fellowship, 2005-06, 2006-07, 2008-09  
Yale University MacMillan Center for International and Area Studies  
*Full tuition support for one year plus stipend*

Dean's Scholarship, 2005-07  
Yale School of Public Health  
*Half tuition support for two years*

Trustees' Scholarship, 1997-2001  
Brigham Young University  
*Full tuition support for four years*

## **TEACHING EXPERIENCE**

2010, 2011     **Teaching Assistant** (2 terms)  
Health Behavior Change at the Individual, Household, and Community Levels  
Instructed by Dr. Peter Winch, Johns Hopkins School of Public Health, Baltimore, MD

2010             **Teaching Assistant**  
Introduction to International Health  
Instructed by Dr. James Tielsch, Johns Hopkins School of Public Health, Baltimore, MD

2006             **Teaching Fellow**  
Public Health Issues in HIV/AIDS  
Instructed by Dr. Kaveh Khoshnood, Yale School of Public Health, New Haven, CT

2001-2003     **Teaching Assistant** (3 semesters)  
Cross-cultural Communications and Field Study Preparation  
Instructed by David Shuler, Brigham Young University, Provo, UT

## PROFESSIONAL DEVELOPMENT

**Languages:** Swahili (Fluent); German (Conversational); Arabic (Basic); Afrikaans (Basic); French (Basic)

**Data Analysis:** Stata, SAS, SPSS, Atlas.ti, MPLUS, Anthropac

**Computer Skills:** PC, Mac, Microsoft Office Suite, iWork, cloud services, EndNote, Sente, VMWare Fusion

**Institutes:** Qualitative Analysis 2: Phenomenological and Narrative/Discourse Methods. North Carolina Summer Research Institutes & Courses, University of North Carolina-Chapel Hill School of Nursing. Jul 23-26, 2012.

**Memberships:** International Association for the Study of Sexuality, Culture and Society (2013-present); American Public Health Association (2013-present); International AIDS Society (2012-present); Global Health Council (2011-present)

**Travel Abroad:** Tanzania, Kenya, South Africa, Germany, Italy, Switzerland, Austria, Turkey, Greece, United Kingdom, The Netherlands, Mexico, Canada, Argentina

**Volunteer:** Coordinator, Student-led Doctoral Dissertation Proposal Development Course (Mar-Apr 2011); Mentor, ACE Mentoring Program, Center for Communication Programs-Tanzania (2012-present); Club Leader, Youth Sexual and Reproductive Health and Life Skills Club, Iringa International School (Apr 2013-present); Owner/Moderator, Iringa Living Expatriate Google Group (May 2012-present)

## PEER-REVIEWED PUBLICATIONS

Layer, E.H., **Beckham**, S.W., Momburi, R. and C.E. Kennedy. (forthcoming 2014). The role of women in male circumcision: Experiences of female partners of male circumcision clients in Iringa, Tanzania. Accepted at *Culture, Health, and Sexuality*.

Layer, E.H., **Beckham**, S.W., Momburi, R. and C.E. Kennedy. (2013). "After my husband's circumcision I know that I am safe from diseases": Women's attitudes and risk perceptions towards male circumcision in Iringa, Tanzania. *PLoS ONE* 8(8):e74391. Doi: 1371/journal.pone.0074391

Kennedy, C.E., Brahmbhatt, H., Likindikoki, S., **Beckham**, S.W., Mbwambo, J., D. Kerrigan. (2013). Exploring the potential of a conditional cash transfer intervention to reduce HIV risk among young women in Iringa, Tanzania. *AIDS Care*. Doi: 10.1080/09540121.2013.824539

Tomori, C., Francisco, L.V., Kennedy, C.E., Kajula-Maonga, L., Likindikoki, S., Babalola, S.O., **Beckham**, S.W., and Mbwambo, J.K., D.L. Kerrigan. (2013). The changing cultural and economic dynamics of polygyny and concurrent sexual partnerships in Iringa, Tanzania. *Global Public Health: An International Journal for Research, Policy, and Practice*. DOI: 10.1080/17441692.2013.815249

Zachary, D. A., A.M. Palmer, **Beckham**, S. W., and P. J. Surkan. (2013). A Framework for Understanding Grocery Purchases in a Low-Income Environment. *Qualitative Health Research*. 23(5):665-78.

Layer, Erica H., **Beckham**, Sarah W., Momburi, Romani B., & Caitlin E. Kennedy

(2013): Understanding the partial protection of male circumcision for HIV prevention among women in Iringa Region, Tanzania: An ethnomedical model. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*. 25(8):1045-50.

Young, S., S. M. Ali, and S. **Beckham**. (2009). The potential role of private pharmacies in maternal iron supplementation in rural Tanzania. *Food and Nutrition Bulletin*. 30(1):16-23.

#### **PRESENTATIONS, PANELS, LECTURES, POSTERS & PUBLISHED ABSTRACTS**

**Beckham**, S.W. "Like Any Other Woman"? Pregnancy, Motherhood, and HIV Among Sex Workers in Southern Tanzania. Doctoral Dissertation Public Defense Seminar. Johns Hopkins Bloomberg School of Public Health. Baltimore, Maryland, Dec 18, 2013.

**Beckham**, S.W. "Like Any Other Woman"? Pregnancy, Motherhood, and HIV Among Sex Workers in Southern Tanzania. Oral Presentation. Center for Qualitative Studies in Health and Medicine. Baltimore, Maryland, Dec 17, 2013.

**Beckham**, S.W., Shembilu, C.R., Brahmbhatt, H. Winch, P.J., Beyrer, C., and D. Kerrigan. Female Sex Workers' Motivations for Family Planning Use and Experiences with Services in Iringa, Tanzania: A Qualitative Study. Oral Presentation. *Tanzania National Family Planning Conference*. Dar es Salaam, Tanzania, Oct 9-11, 2013.

Norris, A.H., Hemed, M., Prickett, A., **Beckham**, S.W., Harrington, B., Hindin, M. Social unacceptability of family planning use among unmarried Zanzibaris. Poster. *Tanzania National Family Planning Conference*. Dar es Salaam, Tanzania, Oct 9-11, 2013.

**Beckham**, S.W., Shembilu, C.R., Winch, P.J., Beyrer, C., and D. Kerrigan. "To Be Called Mama Brings Respect": Respectability, Sacrifice, and HIV Among Mothers Who Engage in Sex Work in Iringa, Tanzania. Oral Presentation. *Conference of the International Association for the Study of Sexuality, Culture, and Society*, Buenos Aires, Argentina, Aug 28-31, 2013. Conference Abstracts, *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care*, 15:spl2, S180-S333. DOI: 10.1080/13691058.2013.817640

**Beckham**, S.W., Beyrer, C., Kennedy, C.E., Likindikoki, S., Mbwambo, J., Brahmbhatt, H., and D. Kerrigan. "An Exceptionally Big Secret": Understanding the Experiences of Men who Have Sex with Men in Rural Tanzania. Oral Presentation. *Conference of the International Association for the Study of Sexuality, Culture, and Society*, Buenos Aires, Argentina, Aug 28-31, 2013. Conference Abstracts, *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care*, 15:spl2, S180-S333. DOI: 10.1080/13691058.2013.817640

**Beckham**, S.W., Shembilu, C., Kennedy, C.E., Brahmbhatt, H., Mbwambo, J., Likindikoki, S., and D. Kerrigan. "Where's Your Husband?": Secrecy and

- Discrimination in Female Sex Workers' Healthcare Seeking Experiences in Iringa, Tanzania. Oral Presentation. *1<sup>st</sup> African Conference on Key Populations in the HIV Epidemic*, Dar es Salaam, Tanzania, Aug 19-21, 2013.
- Beckham**, S.W., Shembilu, C., Brahmbhatt, H., Winch, P., Beyrer, C., and D. Kerrigan. Female Sex Workers' Personal Experiences with Intended Pregnancy and Antenatal Care Services in Iringa, Tanzania. Oral Presentation. *1<sup>st</sup> African Conference on Key Populations in the HIV Epidemic*, Dar es Salaam, Tanzania, Aug 19-21, 2013.
- Beckham**, S.W., C., Kennedy, C.E., Brahmbhatt, H., Mbwambo, J., Likindikoki, S., and D. Kerrigan. Understanding the Experiences of MSM in Rural Tanzania: A Critical Discourse Analysis. Oral Presentation. *1<sup>st</sup> African Conference on Key Populations in the HIV Epidemic*, Dar es Salaam, Tanzania, Aug 19-21, 2013.
- Beckham**, S.W., Shembilu, C., Kennedy, C.E., Brahmbhatt, H., Mbwambo, J., Likindikoki, S., and D. Kerrigan. Multilevel aspects of risks and vulnerabilities among female sex workers (FSWs): developing a targeted combination HIV prevention program in Iringa, Tanzania. Abstract. *XX International AIDS Conference*, Kuala Lumpur, July 2013.
- Beckham**, S.W., "To be called mama brings respect": motherhood, sex work, and HIV in Iringa, Tanzania. Guest Lecturer in *International Studies*, Instructed by Eli Knapp, Houghton College Study Abroad Program, Iringa, Tanzania, March 2013.
- Beckham**, S.W., Focus Group Discussions in Research and Program Implementation. Guest Lecturer for ACE Mentoring Program, Center for Communication Programs, Iringa, Tanzania, Sept 2012.
- Beckham**, S.W., C.E. Kennedy, P. Winch, C. Beyrer, D. Kerrigan. Sex Work, Motherhood, and HIV in Iringa, Tanzania: Roles, Responsibilities, and Risks. Poster. *XIX International AIDS Conference*, Washington, DC, July 2012.
- Layer, E.H., **Beckham**, S.W., Momburi, R. and C.E. Kennedy. (2012). "After my husband's circumcision I know that I am safe from diseases": Women's attitudes and risk perceptions towards male circumcision in Iringa, Tanzania. Poster. *XIX International AIDS Conference*, Washington, DC, July 2012.
- Layer, E.H., **Beckham**, S.W., Momburi, R. and C.E. Kennedy. (2012). The role of women in male circumcision: Experiences of female partners of male circumcision clients in Iringa, Tanzania. Poster. *XIX International AIDS Conference*, Washington, DC, July 2012.
- Kennedy, C.E., Kerrigan, D.D., Brahmbhatt, H., Likindikoki, S., Ntogwisangu, J., **Beckham**, S.W., Beckham, J.R., Celentano, D., and J. Mbwambo. Setting the stage for combination HIV prevention: developing a strategic assessment to inform a cluster-randomized trial in Iringa, Tanzania. Poster. *XIX International AIDS Conference*, Washington, DC, July 2012.
- Zachary, D., A. Palmer, **Beckham**, S.W., and P. Surkan. Constrained Decision Model for Grocery Purchases in a Low-income Urban Environment. Panel: Strategies for

- Increasing Food Access. *Bays, Boundaries, and Borders: Society for Applied Anthropology 72<sup>nd</sup> Annual Meeting*, Baltimore, MD, March 2012.
- Beckham, S.W.** Adherence to Antiretroviral Therapies in Resource-Poor Settings: A Mixed-Methods Case Study in Rural Tanzania. Poster. *AIDS Science Day Conference*, Yale University, New Haven, CT, April 2009.
- Beckham, S.W.** The Kanga as Metaphor: Personal Experiences of Living and Adapting in Zanzibar. Panel. *African Social and Political Cloths: Kanga, Kitenge, and T-Shirts*, SUNY: Empire State College, Syracuse, NY, April 2009.
- Beckham, S.W.** Micronutrient Supplementation as Public Health Intervention: A Case Study of Iron in Zanzibar, Tanzania. Guest Lecturer in *Nutrition in Developing Countries*, Instructed by Sera Young, UC—Berkeley, Berkeley, CA, February 2008.
- Young, Sera, and S.W. **Beckham.** Blood, Pills, and the Power of the Private Sector: Accessing Private Pharmacies for the Treatment of Maternal Anemia in Zanzibar, Tanzania. Oral Presentation. *10 Years of AMMA Conference: Teaching and Applying Medical Anthropology Conference*, University of Amsterdam: Amsterdam Master's in Medical Anthropology, Amsterdam, The Netherlands, May 2007.
- Beckham, S.W.** Maternal Anemia in Pemba: Access and Barriers to Treatment. Oral Presentation. *African Studies Brown Bag Series*, Yale University MacMillan Center for International and Area Studies, New Haven, CT, November 2006.
- Beckham, S.W.** From Malaria Patient to Public Health Professional. Oral Presentation. *Alumni Speaker Series*, David M. Kennedy Center for International and Area Studies, Brigham Young University, Provo, UT, September 2006.
- Beckham, S.W.** Remedies for STI and Associated HIV Risk in sub-Saharan Africa. Guest Lecturer in *Public Issues in HIV/AIDS*, Instructed by Kaveh Khoshnood, Yale School of Public Health, New Haven, CT, April 2006.
- Beckham, S.W.** Contagion, Cleansing, and Cure: Remedies for STI and Associated HIV Risk in sub-Saharan Africa. Oral Presentation. *African Studies Brown Bag Series*, Yale University MacMillan Center for International and Area Studies, New Haven, CT, April 2006.
- PAPERS UNDER REVISION, REVIEW & IN PREPARATION**
- Beckham, S.W., Shembilu, C.R., Winch, P.J., Beyrer, C., and D. Kerrigan.** (2013). "Do you have a husband?" Female Sex Workers' Experiences with Intended Pregnancy and Antenatal Care Services in Southern Tanzania. In Preparation for *Studies in Family Planning*.
- Beckham, S.W., Shembilu, C.R., Winch, P.J., Beyrer, C., and D. Kerrigan.** (2013). A Qualitative Exploration of Female Sex Workers' Experiences with Contraception in Southern Tanzania. In Preparation for *Contraception*.

**Beckham**, S.W., Shembilu, C.R., Winch, P.J., Beyrer, C., and D. Kerrigan. (2013). “If you have children, you have responsibilities”: Motherhood, Sex Work, and HIV in Southern Tanzania. In Preparation for *Social Science and Medicine*.

Chase, R., Dreibelbis, R., **Beckham**, S.W., Rahman K.M., Arifeen S.E., and P. Winch. (2013). Adherence of village doctors in rural Bangladesh to guidelines for assessment and treatment of childhood pneumonia. In Preparation.